

All About Herbs Thermal Imaging New Client Intake Form

Name: _____

Date of Birth: _____ Age: _____

Street: _____

Town, State, Zip: _____

Phone Number: () _____ - _____

How did you hear about us? _____

Current Concerns or Symptoms:

Diagnosed medical problems: (high blood pressure, diabetes, arthritis, cancer, etc)

Infusion port or internal device? (Breast thermals will need to be rescheduled 90 days after port is removed)

Previous surgeries or Biopsies / Dates:

Current medications: (Prescriptions only)

Family History:

*This information is confidential.
All information is correct and current to my knowledge.
No medical information has been intentionally been omitted for the purpose of this report.
Doctors need full disclosure to make an accurate reading.
Thermograms are not a replacement for mammograms.
Please call **907-376-8327** if you have questions or need to reschedule.*

Signature: _____ Date: _____

Thermographer: _____

Authorization to Use or Disclose Protected Health Information
All About Herbs

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, *All About Herbs* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: ____/____/____ through ____/____/____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

Mailing Address.

If appropriate, please contact me at the following address:

Phone.

If appropriate, please contact me by telephone at the following number:

Fax.

If appropriate, please contact me by fax at the following number:

E-Mail.

If appropriate, please contact me by E-mail at the following E-mail address:

**I have the following additional requests for confidential communications regarding my Protected Health Information:
(Please explain)**

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

Signature

Date

Accepted as requested.

Modified as noted: _____

Authorized Signature of Facility

Date

All About Herbs NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All About Herbs is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

We only submit your health information to EMI for the sole purpose of interpreting you thermal scans.

We only submit your EMI Report to you at the mailing or email address you have provided.

We do not share your information with anyone else, unless we are required to do so by law.

Marketing and Contact.

As a courtesy we may contact you via telephone, text message or email to remind you of your appointment, or to remind you to make a follow up/annual appointment. We will not include any personal health information in these messages.

We will not use your information for any marketing, unless you request to be on our newsletter email list.

Change of Ownership.

In the event that **All About Herbs** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **All About Herbs** is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that **All About Herbs** amend your protected health information. Please be advised, however, that **All About Herbs** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by **All About Herbs**.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

All About Herbs reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **All About Herbs** is required by law to comply with this Notice.

All About Herbs is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: **Dawn Nelson** by calling the office at 907-376-8327. If **Dawn Nelson** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how **All About Herbs** has handled your health information should be directed to **All About Herbs** by calling the office at 907-376-8327. If **All About Herbs'** manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
 200 Independence Avenue, S.W.
 Room 509F HHH Building
 Washington, DC 20201

This notice is effective as of ____ / ____ / ____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **All About Herbs** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

 Patient's Name (print)

 Patient's Signature

 Date

 Authorized Facility Signature

 Date

Confidential Questionnaire for Women's Health Check

NAME _____ Date of Birth _____

Please mark YES or NO as it applies to you:	YES	NO
Any close relative ever had breast cancer?		
Ever been diagnosed with breast cancer? Left 5 Right 5 Date:		
Diagnosed with any other breast disease? (Fibrocystic, Mastitis, Cystic, Abscess)		
Any biopsy or surgery to your breasts? Left 5 Right 5 Date:		
Cosmetic surgery to breasts? (implants, reduction, lift) Left 5 Right 5 Date:		
Do you have dense breast tissue?		
Have you had a mammogram in the past 12 months?		
Have you had more than 30 mammograms in your lifetime?		
Mammogram in the past 5 years? Date of most recent mammo or U/S:		
Any abnormal results from any breast testing?		
Ever taken a contraceptive pill for more than 4 years? How long?		
Ever diagnosed with ovarian, uterine or cervical cancer?		
Ever taken hormone replacement therapy? (pharmaceutical or bio-identical)		
Do you have an annual physical breast examination by a doctor?		
Do you perform a monthly breast self-exam?		
Did your periods start before the age of 12?		
Did your periods end after the age 50?		
Are you still having a menstrual cycle?		
Have you ever given birth to a child?		
Have you ever smoked for more than 5 years?		
Is your menstrual cycle irregular?		
Do you experience cramping during your menstrual cycle?		
Do you have heavy bleeding with your menstrual cycle?		
Do you have breast pain or tenderness that comes and goes?		
Do you have any breast lumps that come and go?		
Do you have low libido? (low sex drive)		
Do you have hot flashes?		

Confidential Questionnaire for Women's Health Check

Please mark YES or NO as it applies to you	YES	NO
Have you ever been diagnosed with endometriosis?		
Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)?		
Have you ever been treated for infertility?		
Do you have any swelling in the neck or trouble swallowing?		
Any thyroid disorder? (hypothyroid/ hyperthyroid/ Hashimoto's/ Grave's disease)		
Do you regularly experience fatigue?		
Have you experienced recent hair loss?		

Have you recently had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	Right Breast	Left Breast
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Have you had any type of Vaccination in last 4 weeks? LEFT ARM RIGHT ARM NO

PATIENT DISCLOSURE:

I understand that the Report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature _____ Date _____

THERMAL IMAGING IS:

- *Non Invasive
- *No Radiation is Emitted
- *Painless
- *FDA Cleared

Preparation for your scan is simple but critical to the accuracy of the results. Please be advised, failure to follow these simple guidelines will require us to reschedule your appointment and FEES WILL APPLY if we are unable to proceed with your originally scheduled time slot.

BEFORE THE APPOINTMENT:

- *Fill out the required forms online
- *Avoid strong sunlight exposure the day of, and sunburn in the days preceding your appointment
- *No massage, chiropractic adjustments, acupuncture, physical therapy, infra-red saunas the day of your scan
- *Avoid the application of creams, liniments, oils, or lotions, including but not limited to perfume and cologne
- *No smoking for a minimum of 2 hours prior to your scan
- *No vigorous exercise 2 hours prior to your scan.
- *Remove all jewelry and earrings
- *Long hair should be worn up
- *It is very important to wear loose fitting clothing. The thermography scan will be delayed until irritation marks in the skin caused by tightly fitting garments have dissipated.
- *Deodorant and light make up ARE permitted

AT THE CLINIC:

Arrive a few minutes early to your appointment. Your body will take some time to adjust to the temperature of the room. You will be given a cover to change into, as you will be disrobing down to your underwear. Speedo type undergarments or thongs are appropriate for both men and women. You will meet your thermographer who will explain and demonstrate the required views and positions necessary for your scan. Thermal images are then taken of either the whole body or just the regions of interest. Neurological testing can include a cold stress test which simply involves placing a hand or foot in a cool bowl of water or having a gel pad applied to any part of the body.

You are welcome to bring a friend, partner or spouse into the imaging room for the scan.