# All About Herbs
# Thermal Imaging New Client Intake Form

Name:_____ Date:_____

Date of Birth:_____

Mailing Address:_____

_____

Phone Number:_____

Email address:_____

How did you hear about us?_____

## Symptoms & History

Age:_____ Gender:_____

Primary Care Physician:_____

Referring Physician:_____

Current Concerns:_____

_____

Current Symptoms:_____

_____

Current Treatments:_____

_____

Current Prescription Medication:_____

_____

Have you had a thermogram at All About Herbs before?_____

_____

If yes, was there recommendations to follow up with your doctor?_____

If yes, did you and what was the outcome?_____

Please list any surgeries you have had with date, (just the year is fine):_____

_____

_____

Dental History, check all that apply:

amalgam fillings root canals bridges crowns periodontal disease

Would you describe your general health as good, fair, or have concerns?_____

_____

Please list immediate family health history, include family member and disease (example: father heart disease)._____

_____

_____

Do you have any medical diagnoses?_____

_____

_____

Do you have any skin lesions or physical abnormalities in the area we will be scanning?_____

_____

(Female Patient Only)

Do you have any abnormal Ob/Gyn History?_____

Is there anything else you would feel is important for us to note?_____

_____

# DISCLAIMER

**The Thermal Imaging report is designed to support, NOT REPLACE, the relationship that exists between you and your Physician. It is a procedure that can alert your doctor to changes that may indicate early disease. It is not intended to replace the Medical Advice of your doctor or licensed medical provider. It is not intended to treat, or cure any ailment you may or may not have.**

**The information contained within the report is to be used for informational and educational purposes only. Please consult your healthcare provider for advice about a specific medical condition.**

**Furthermore, you are being assisted by a Certified Clinical Thermographer who IS NOT A LICENSED PHYSICIAN.**

- **Any questions discussed in context to the generated report *IS NOT A DIAGNOSIS.***
- **Any health related information shared between persons *IS NOT MEDICAL ADVICE AND SHOULD NOT BE TREATED AS SUCH.***

**CONSULT YOUR PHYSICIAN WITH MEDICAL INQUIRIES OR SPECIFIC DIAGNOSIS RELATED QUESTIONS.**

**Printed name:** _____ **Date:** _____

**Signature:** _____

# 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

# 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:

**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. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. 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 of 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

# Breast Thermography Confidential Questionnaire

**Name:**_____ **Birthdate:**_____

**Address:**_____ **City:**_____ **Zip:**_____

**Email:**_____ **Phone:**_____ **Doctor:**_____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

| Please Mark Yes Or No As It Applies To You: | Yes | No |
|---|---|---|
| Do you have any close relative who has had breast cancer? | | |
| Have you ever been diagnosed with breast cancer? | | |
| Have you ever been diagnosed with any other breast disease (fibrocystic)? | | |
| Have you had any biopsies or surgeries to your breasts? | | |
| Have you had any breast cosmetic surgery or implants? | | |
| Have you had a mammogram in the past 12 months? | | |
| Have you had a mammogram in the past 5 years? | | |
| Have you had abnormal results from any breast testing? | | |
| Have you ever taken a contraceptive pill for more than a year? | | |
| Have you suffered with cancer of the womb? | | |
| Have you had pharmaceutical hormone replacement therapy? | | |
| Do you have an annual physical examination by a doctor? | | |
| Do you perform a monthly breast self exam? | | |

| |
|---|
| How many mammograms have you had in total? _____ |
| What was your age when you had your first mammogram?_____ |
| How many births have you had?_____ Your age at the birth of your first child:_____ |
| Did your period start before the age of 12?_____ Or finish after the age of 50?_____ |
| Do you smoke? Yes____ Never____ Not in the last 12 months____ Not in the last 5 years____ |
| Had a vaccination in last 4 weeks? Indicate which arm: Left ___ Right ___ No ____ |

# Breast Thermography Confidential Questionnaire

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 | | |

**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 _____