# 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.

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- 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

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# 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*

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# 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

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