DIAGNOSTIC Ultrasound Intake Form

MEND Thermography - (515) 207 - 4803
8515 Douglas Ave Suite 25, Urbandale, IA 50322

Patient Information

Name _____ Age _____ DOB _____
Address _____ City, State, Zip _____
Phone _____ E-mail _____
Gender: ☐ Male ☐Female Primary Care Physician _____
Preferred method of communication: ☐ Any ☐E-mail ☐Text ☐ Call—may we leave a message? ☐ Yes ☐No
Emergency Contact: _____
Relationship _____ Phone _____
Who can we thank for referring you? _____
How would you like your report sent to you? ☐ Secure E-mail ☐Office Pick-up ☐Mail (+$3.99)

Referral Information

Referring Physician Name _____ Clinic Name _____
Phone Number _____ Fax Number _____
We will automatically provide a report to your referring physician. Please contact their office to review your results.

Health Information

Reason for today's appointment: _____
Current Symptoms/Concerns _____
_____
List Medical Diagnoses _____

Surgical History

Previous Surgeries & Year? ☐ None
_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____

Ultrasound History

Have you had an ultrasound of this same area before? ☐ Yes ☐ No

If YES, Was your previous exam done with our company? ☐ Yes ☐ No

If NO, please bring a copy of your previous report and/or copy of images to your appointment for us to upload to the Radiologist for comparison

Breast Scans Only:

Do you have any of the following symptoms?

☐ Breast Pain ☐ Breast Tenderness ☐ Lumps ☐ Change in breast size

☐ Secretion of nipple ☐ Skin thickening or dimpling ☐ Nipple Inversion

If YES, Describe location: _____

Is this exam due to an abnormal **mammogram**? ☐ Yes ☐ No

If YES, please bring in any previous reports or discs with images you have to your appointment

Have you ever been diagnosed with breast cancer? ☐ Yes ☐ No

If **NO**, move on to next section

If **YES**: please provide the following details:

Cancer Type? ☐ Metastatic ☐ Local ☐ Lymph Node Involvement

When Diagnosed: Month _____ Year _____

Which Breast? ☐ Left Breast ☐ Right Breast

Location? ☐ Upper Outer ☐ Upper Inner ☐ Lower Outer ☐ Lower Inner ☐ Nipple

Treatment? ☐ Surgery ☐ Chemo ☐ Radiation ☐ Other ☐ None

Have you ever been diagnosed with other breast disease? ☐ Yes ☐ No

If **YES**: ☐ Fibrocystic ☐ Cystic ☐ Mastitis ☐ Abscess ☐ Other

I verify the accuracy of the information above. I authorize Mend Thermography to furnish any medical information requested and to release this questionnaire and the images from my scan to Vesta Teleradiology for interpretation. I understand that I am financially responsible for the charges related to this ultrasound examination.

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE DATE

Informed Consent for Diagnostic Ultrasound

Please read carefully and sign below if you are in agreement with this consent form. Please ask questions if there is anything that you do not understand on this consent form.

I understand:

- Throughout this informed consent document, Mend Integrative Wellness Center LLC (DBA Mend Thermography) together with any and all employees and independent contractors is referred to as "MEND."
- Ultrasound is an imaging method that uses sound waves to create pictures or videos of the inside of your body. According to the FDA, ultrasound imaging has been used for decades and has an excellent safety record. It is based on non-ionizing radiation, so it does not have the same risks as other types of imaging systems that use ionizing radiation. Although ultrasound imaging is generally considered safe when used prudently by appropriately trained health care providers, ultrasound energy has the potential to produce biological effects on the body. Ultrasound waves can heat the tissues slightly. In some cases, it can also produce small pockets of gas in body fluids or tissues (cavitation). The long-term consequences of these effects are still unknown. By signing this consent form I accept all potential risks associated with ultrasound screening.
- Ultrasound is not the same as and does not replace other radiology assessments, mammography, blood labs, or any other forms of testing.
- I understand that no health evaluation/imaging is perfect and screening is NOT 100% accurate. False positives can occur with any type of screening test. Age, breast structure, body habitus, or other circumstances may limit the ability to detect all abnormalities and result in a false negative. I waive any liability to MEND should I have a false negative or false positive report.
- Some ultrasound tests have prescreening requirements (ie – fasting, water intake). I have been given a preparation sheet with instructions to ensure the most accurate ultrasound evaluation possible. If I fail to comply with these prescreening requirements, I take full responsibility and know that this can compromise my results.
- During my ultrasound exam, I may be required to remove certain garments and wear a gown. I also understand that the technologist performing my exam must maintain a close proximity to me during the examination and must engage in contact with the area to be examined to satisfy the logistical requirements for successful completion of the exam. I understand that this is necessary and will be executed in a strictly professional manner with respect to my dignity and privacy. I waive any liability to MEND should I suddenly find objection to this during my examination.
- My exam will be performed by a Registered Diagnostic Medical Sonographer. A board-certified Radiologist will review my images and the written results will be faxed to the referring provider. Ultrasound reports include written results of the findings but no images. A flash drive of the images may be requested by your physician. I understand I should contact my physician's office to get results of my ultrasound.
- I am fully aware that ultrasound technicians at MEND are not physicians and are not responsible for my medical care and medical decisions. I understand that any medical providers on staff at MEND are not my personal medical providers unless I have previously established care with them and remain actively under their care. I understand and agree that staff member(s) or independent contractor(s) will not make decisions on my behalf and is not to be held responsible for any decision I choose to make after reviewing my report, and that any further testing, evaluation, and explanations should be deferred to my doctor.

Continue on to next page.

To confirm you have read this page, please initial here: _____

- The report generated from my images is intended for use by trained health care 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 am responsible for my own decisions regarding my health, wellness, and nutrition. Therefore, MEND cannot be held responsible for any decisions I make. MEND is not responsible for any supplements/care products I use or purchase through their store or online dispensary. I understand that I should talk with my physician before using any supplements or making lifestyle changes.
- MEND reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to MEND at 8515 Douglas Ave Suite 25, Urbandale IA 50322.
- I hereby give my consent for MEND to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). With this consent, MEND may email, mail, or call and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care. No test results, however, will be left on voicemail or with any person without a specific request by me to do so. I have the right to request that MEND restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to MEND use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.
- MEND will keep my information confidential unless I provide a written release or as required by law (HIPAA).

By signing below, I certify that I have read and understand the statements above, I have received satisfactory answers to all questions I may have had, and I consent to the ultrasound examination.

Patient Signature:_____ Date:_____

Printed Name of Patient:_____

Payment Agreement & Financial Policy
Diagnostic Ultrasound

CLIENT NAME:_____DATE OF BIRTH: _____

CHARGES: I understand that I am and will be responsible for all charges related to the services provided to me by Mend Integrative Wellness Center LLC (MEND THERMOGRAPHY); and that the charges presented to me are due in full at the time of my appointment, unless previous arrangements have been made. Mend Thermography accepts cash, check, and all major credit cards for payment. I understand that the charge for this appointment includes: single ultrasound exam and radiology report. All other follow-up tests, imaging, bloodwork, or medical appointments are not included in this fee and it is my sole responsibility to pay for any additional workup that is done.

INSURANCE: Mend Thermography does not file insurance. If I have received a doctor's order for this exam, I will receive a detailed receipt to submit to my insurance. If ultrasound is covered by my insurance policy, it is my sole responsibility to file and obtain reimbursement from my insurance company and that it is still not a guarantee of coverage. If requested, you will be provided with a basic receipt of payment and description of the service rendered. Flexible Spending Account, health Savings Account and Aflac have accepted and reimbursed for various health screenings, this however is not a guarantee of coverage.

By signing below, I agree to Mend Thermography's financial policy and payment agreement and will provide payment for services.

Patient Signature:_____ Date:_____

Printed Name of Patient:_____