Return Thermography Client Update Form

Patient Information

Name _____ Age _____ DOB ____/____/___

Has your contact information changed since your last appointment? ? ☐ No ☐ Yes (If yes, please update information below)

Address _____ City, State, Zip _____

Phone _____ E-mail _____

Health Information

List Any Clinical Concerns/Symptoms _____

_____

_____

Have you had medication changes (including bioidentical hormones) since your last visit? ☐ No ☐ Yes (list below)

_____ _____ _____

Any New Medical Diagnoses? _____

Health Histories

Mammogram/Ultrasound History Date of last mammogram and/or ultrasound? _____

Any noted abnormalities? ☐ No ☐ Yes _____

Any changes since your last visit? *(explain)*

Surgical: ☐ No ☐ Yes _____

Dental: ☐ No ☐ Yes _____

General History: ☐ No ☐ Yes _____

Family Health History: ☐ No ☐ Yes _____

Had a vaccination in last 4 weeks? Indicate which arm: Left ☐ Right ☐ No ☐

Anything else important we should know? _____

Report & Interpretation Consent

How would you like your thermography report sent to you? ☐ Secure E-mail ☐Office Pick-up ☐Mail (+$3.99)

- If you'd like to have reports sent via secure e-mail or USPS mail, please make sure the contact information on file is accurate and/or updated at the top of this page if it has changed. By signing this consent, you agree to the method selected above for transfer of protected health information (your thermography report). If USPS mail is the selected method, you agree to pay the additional cost associated with this method.

Patient Signature: _____ Date: _____

Informed Consent for Thermography

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:

- Thermography is simply a procedure utilizing thermal imaging cameras to visualize and obtain an image of the infrared radiation (heat) coming from the surface of the skin. The Thermographic procedure is performed as an aid to the evaluation of abnormal temperature patterns which may or may not indicate the presence of a disease process.
- A thermogram is not a stand-alone diagnostic tool. It is an adjunctive tool, which while reliable, should be used by the primary care physician along with other diagnostic tests and analyses to arrive at a provisional or more complete diagnosis. No surgical procedure should be based on thermography alone.
- Thermography is not a replacement for any anatomical imaging tests (mammography, ultrasound, CT, MRI, etc.). Results of your thermogram may require further investigation by one or more of these tests.
- I will be disrobed relevant to the imaging area to allow the surface of my body to cool to an ambient room temperature. I will then be examined with a DITI camera by a certified thermographer.
- My images will be interpreted by a board-qualified or board-certified thermologist from Electronic Medical Interpretation Inc. This report will only be an analysis of the thermographic findings and will not be a guarantee that an illness, disease, or condition is present or absent.
- It is my responsibility to provide my health care provider with my report for further diagnosis and analysis in the overall evaluation of my health. Thermography is not a replacement for medical care, and I intend to remain under the care of my primary healthcare provider.
- I have been given a preparation form to ensure the most accurate thermographic evaluation possible. I have informed the thermographer of any skin lesions/bruises/wounds/etc. that may cause changes in my images.
- I am responsible for my own decisions regarding my health, wellness, and nutrition. Therefore, MEND Thermography cannot be held responsible for any decisions I make. MEND Thermography 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.
- I am aware that this procedure is not covered by insurance and that the office fee is due and payable at the time of service unless special provisions have been made with the office in advance.
- MEND Thermography will keep my information confidential unless I provide a written release or as required by law (HIPAA). As required by the Privacy Regulations, MEND Thermography 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 (thermal images and related health history) to the following person(s), entity(s), or business associates of this office: EMI (Electronic Medical Interpretations), for the purpose of interpretation of thermal images.
    - EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; or permission is withdrawn in writing; or a specific requested date.
    - RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named listed above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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 thermographic examination and provide consent to send my thermal images to the interpreting company listed above.

Patient Signature: _____ Date: _____

Printed Name of Patient: _____