INSIGHT THERMAL IMAGING



Name					
Date of ex	Date of examCell Phone				
Address_					
City		State	Zip code		
Email whe	ere you wan	t your result	s to be sent		
•		ke your resul	lts to go		
	of your provi				
City			State		
Zip Code_					
		OFFICE (USE ONLY		
BP	NP	FU	Scores		



Insight Thermal Imaging Patient Preparation Checklist

It is crucial that you follow these restrictions in order to achieve accurate results from your thermal scan.

- * No prolonged sun exposure (especially sunburn) to the body area being imaged for five days prior to your exam.
- * Avoid a strenuous workout, exercise or weight training for 24 hours prior to your test. No sexual activity for 24 hours prior.
- * If you are nursing, please try to nurse as far from one hour prior to the exam as possible.
- * Do not use a car seat heater while travelling to your thermal imaging appointment.
- * No physical therapy, massage, EMS, TENS, ultrasound treatment, acupuncture, chiropractic, physical/sexual stimulation, hot or cold pack use for 24 hours before your exam.
- * Do not use lotions, powder, deodorant, antiperspirant, perfume, scented products, makeup or anything topical on the body area to be imaged the day of your exam.

 Our clinic has a **NO CHEMICALS/NO SCENTS** policy
- * If any areas of the body (as included in the images) are to be shaved, this should be done the evening before the exam. Do NOT shave under your arms the day of your exam.
- * Allow at least 4 hours after a hot shower, hydrotherapy, hot tub or sauna.
- * Do not smoke or have any caffeine for 2 hours prior to your exam.
- * If bathing, it must be no closer than 1 hour before your exam.
- * If not contraindicated by your doctor, avoid the use of pain medications the day of your exam. You must consult with your doctor prior to any change of medication.
- * If you have had any medical procedure within the past 12 weeks, please notify our office before coming in for your appointment.
- * Let the technician know if you have had any recent skin lesions or blunt trauma to the area to be scanned.

Please note: For breast exams you will be asked to disrobe from the waist up.

Breast Health History



Name:	Age:		Date of Scan:
Date of Birth:	Sex:	F M M	Initial Scan ☐ Follow-up Scan ☐
Describe any current breast concerns such	n as lumps, pain, sk	kin changes, ra	diographic findings or other concerns
MARK THE AREA OF ANY CURF	RENT CONCE	RN ON THE	DIAGRAM:
R	0	(a) L	R
Last Physical Breast Examination by a Hea			
Last Mammogram: ☐ None			
Date: □ Right □ Left Results: □ Normal Other			
Last Breast Ultrasound: ☐ None			
Date: □ Right □ Left Results: □ Normal Other			
Last Breast MRI: ☐ None			
Date: ☐ Right ☐ Left Results: ☐ Normal Other			
Breast Biopsy: ☐ None Date: ☐ Right ☐ Left Results: ☐ Benign ☐ Pre-Cancer ☐ C			

Section 1: Breast Cancer ☐ None ☐ Left ☐ Right ☐ Both Date of Diagnosis:
Cancer Treatment:
☐ Lumpectomy: Date: ☐ Mastectomy: Date:
□ Reconstruction: Date: □ Radiation treatment: Date of last treatment
Other treatment
Section 2: General
Benign Breast Surgery: ☐ None Lumpectomy: Date: ☐ Right ☐ Left
Implants: Date: Reduction: Date:
Fibrocystic breasts, Breast Cysts, or General Breast Lumpiness □Yes □ No
Other benign breast conditions: None Yes
Currently Breast feeding: ☐ No ☐ Yes - Last Breast Nursed: ☐ Right ☐ Left Breast Most Favored: ☐ Right ☐ Left
Pregnant: ☐ Yes ☐ No - current cycle day (# of days since 1st day of period):
Menopause: ☐ No ☐ Yes - Age of last menses:
Currently experiencing symptoms of: ☐ Menopause ☐ Perimenopause ☐ Neither
Both ovaries removed: ☐ Yes - Check only if both have been removed ☐ No
Family history of breast cancer: ☐ Yes ☐ No
Past injury to the breasts: ☐None ☐ Right ☐ Left ☐ Both Date of Injury:
Section 3: Selected Hormones and Factors Effecting Them
Current Hormones: None
☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ Thyroid hormone
Current supplements to support the following: ☐ None
☐ Breast Health ☐ Hormonal Balance ☐ Inflammation ☐ Thyroid Function
Are you currently engaged in any lifestyle activities or diet designed to: \square None
☐ Promote breast health ☐ Reduce inflammation ☐ Promote hormonal balance
PLEASE DO NOT WRITE IN THIS SECTION
Tech:PatientTemp:F LaboratoryTemp:C

INFORMED CONSENT FOR TESTING PROCEDURE

screen provider, no duty to protect or warn in mitigate any risks, known or unknown, relat monitor provider's services for my own safet By signing this Statement of Independent	ty and protection. Operations, I understand and agree e Thermal Imaging Interpretive Service.	e with the foregoing and further agree that E ces is only responsible to me for the content	Dr.
screen provider, no duty to protect or warn mitigate any risks, known or unknown, relat		all duty of reasonable care to select, screen al	
referred to as "Kane Interpretive Services' services solely for the purpose of interpretice director, partner, representative or agent of director, partner, representative or agent of your provider and does not oversee or su involved in the design, manufacture, mark machinery or products used by your provider provider solely to interpret thermal imaging nor have the right to control, your provider Kane Interpretive Services makes no promi	") is a California based company the ing and reporting thermal imaging so Kane Interpretive Services. Nor is K your provider. Kane Interpretive Ser- pervise your provider's thermography eting, sale, rental, distribution, install der. Rather, Kane Interpretive Service data and to report the results. Kane 's business, including its equipment, ses, warranties or representations, ex- es no duty of care to me in connection	rmal Imaging Interpretive Services (collective at contracts with the provider of your imaginans. Your provider is not an employee, office ane Interpretive Services an employee, office vices is a wholly separate business entity from yoperations. Kane Interpretive Services is a lation, inspection, repair or modification of an easies is an independent contractor hired by your Thermal Interpretive Services does not contract operations, advertising and/or representation and with provider's services, including no duty independent on duty to investigate, communicate and duty of reasonable care to select screen as	ng er, er, om not ny our ol, ses. to or
STATEMENT OF INDEPENDENT OPER	RATIONS:		
Print Name	Signature	Date	
By signing below, I hereby acknowledge th opportunity to ask any questions I may have received sufficient information with respect	at (1) I have read and understood ea ave had; (3) any questions I asked to thermal imaging to make an info	each of the above paragraphs; (2) I have had a were answered to my satisfaction; (4) I have med decision to undergo the procedure; (5) I future cancer will be detected; and (6) I here!	an ve) I
		aging provided to me before the examination	
or screening. I also understand that there cancer. Nor can it rule out the presence changes at the surface of the breasts to thermal imaging revealing a low risk. For the breast concerns including but not limited and radiographic findings require evaluations.	t ultrasound and breast MRI and domal imaging does not and cannot does of breast cancer since some carbbe seen with thermography. Therefore the treason, thermal imaging does roughly to skin changes, nipple discharge, tion by a medical doctor regardle	pary screening examinations such as physical content of the property of the pr	on ast ire ite All gs of

Insight Thermal Imaging

Informed Consent for Digital Thermographic Imaging



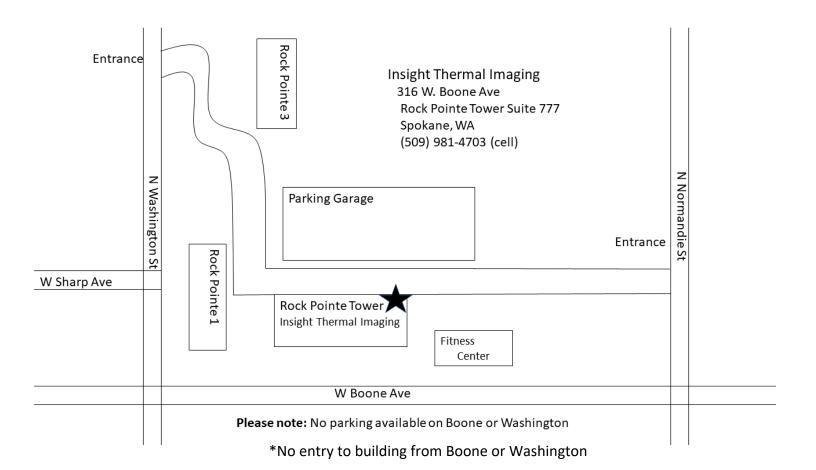
I	give Insight Thermal Imaging permission to
electronically transfer my medical images via em	nail, to the email address I have provided. Additionally, I
would also agree to send these images electronic	cally to the medical provider listed. (Provider listed unde
"Person In Charge of Your Breast Health" on you	r breast health history form).
Signed	Date

ATTENTION: THIS EMAIL IS PROTECTED BY FEDERAL LAW UNDER HIPAA GUIDELINES.

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Map to Insight Thermal Imaging office



Insight Thermal Imaging Fees



Below is the fee for breast thermal imaging procedures.

I have read and agree to the financial terms and cancellation policy above:

Insight Thermal Imaging does not bill insurance plans. Some insurance plans may reimburse you for our services. It is up to you to submit our bill to your insurance carrier if you so choose. In any event, complete payment for our services is due at the time of service.

Cancellation Policy: Patients will be billed for any appointment cancelled with less than 24 hours' notice. There is a \$50.00 missed appointment fee.

I understand that I am wholly and personally responsible for payment on date of service. Insight Thermal Imaging is not a participant in Medicare or insurance plans. I realize that I may request the attending physician's statement of diagnosis and services provided to me, which I may submit to my insurance company for reimbursement of the treatment cost, as may be provided by my plan. Insight Thermal Imaging does not guarantee that I will receive reimbursement from my insurance carrier.

		•
Date	Signa	ature
Invoice		
_		
Procedure	Description	Fee
Insurance Code		
99386 thermo	Breast Thermogram	\$215
*see below	MammaCare ® clinical breast examination	\$75

ΒP

*Depending on you	r age, your	insurance	code m	ay vary	

Out of area fee

Age Up to 39 Insurance Code 99385 Age 40 to 64 Insurance Code 99386 Age 65 and up Insurance Code 99397

Results to Dr.

Insight Thermal Imaging Tax ID #45-4780201

Total Charges:

\$25

Method of Payment_