Breast and Body Thermography

PATIENT INFORMATION SHEET

This information is confidential.

Name: _____ **DOB:** _____

Address: _____

Phone: _____ **Cell:** _____

Email: _____

Have you done Thermography before? If so, what were the results?

Medical History/Previous Illness:

Previous Surgery (Including Dental):

Current health problems or concerns:

Scar tissues/Skin Abnormalities(Tattoos):

Medications (Vitamins/Herbs):

Family History:

Other Treatment:

Current Doctor:

Address:

Phone #:

All information is correct to my knowledge.

I acknowledge I have received copies of brochures from ACCT (or read them on the website). I have reviewed the indications for Thermography as per the ACCT website. I understand that Thermography (DITI) is an adjunctive diagnostic tool and is not a stand alone diagnostic test. Verbal statements or opinions expressed by any staff or contractors of BB Thermography are null and void to the information provided by the ACCT. Thermography does not diagnose, treat, cure, or prevent any medical illness or disease.

Signed: _____ **Date:** _____

Breast and Body Thermography

Upper Body Study Questionnaire

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.

Name: _____ **D.O.B:** _____

Address: _____

Phone: _____ **Your Doctor:** _____

Please Show areas of :

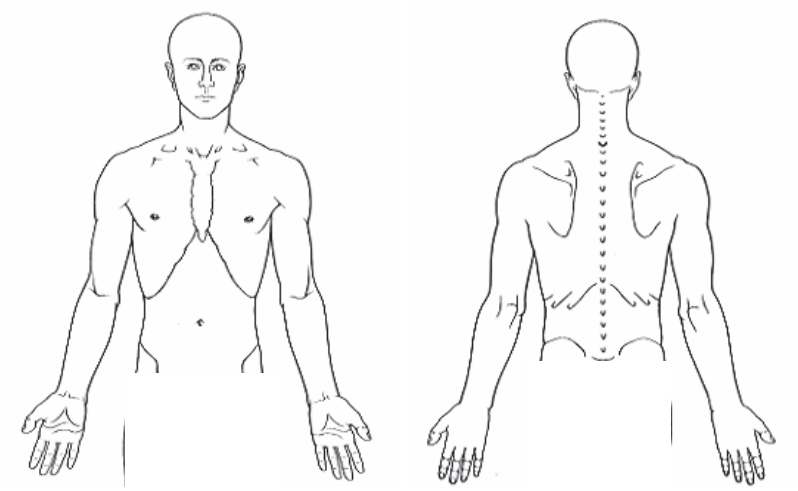
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring ↗



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries / Fractures / Surgery

PATIENT DISCLOSURE

I understand that 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 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 of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ……..

Authorization to Use or Disclose Protected Health Information

Breast and Body Thermography

Patient Name**:**_____

Address: _____

Date of Birth: _____ Date of Request**:**_____

As required by the Privacy Regulations, *Breast and Body 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 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 (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. 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 or Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

Breast and Body Thermography

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**. ($10 Fee per report)
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:
__**N/A**_____

☐ **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 and Body Thermography
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.

Breast and Body Thermography 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

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership.
In the event that **Breast and Body Thermography** 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 Breast and Body Thermography 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 **Breast and Body Thermography** amend your protected health information. Please be advised, however, that **Breast and Body Thermography** 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 **Breast and Body Thermography.**

- 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

Breast and Body Thermography 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, **Breast and Body Thermography** is required by law to comply with this Notice.

Breast and Body Thermography 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: the office manager by calling this office at 832-653-6868. If office manager 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 **Breast and Body Thermography** has handled your health information should be directed to the office manager by calling this office at 832-653-6868 If office 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 April / 01 / 2021

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Breast and Body Thermography 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

