CLIENT INFORMATION & ULTRASOUND CONSENT FORM

678-688-8986 | office@mobile-thermographic-imaging.com
www.atlanta-breast-thermography.com

NAME:_____DATE OF BIRTH:_____

AGE:_____GENDER: MALE_____FEMALE_____HOME#:_____

CELL#: _____ MAY WE TEXT YOU TO CONFIRM FUTURE APPOINTMENTS? YES ☐ NO ☐

EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

REFERRED BY (PHYSICIAN, FRIEND, INTERNET, ETC.): _____

ULTRASOUND ACKNOWLEDGEMENT/CONSENT FORM

*Initial*_____ I hereby authorize Mobile Thermographic Imaging (a/k/a 'MTI' and referred herein as 'MTI') to perform an ultrasound screening. In requesting this ultrasound screening, I understand and acknowledge that it is a screening test only, and that the results do not in any way constitute a medical diagnosis, and will not tell me whether I have any illness, disease, or other condition. I also understand and acknowledge that these screening tests do not substitute for regular health care or a physician exam, and that this ultrasound screening test is not the same as and does not replace mammography, blood labs, or any other forms of testing. I understand it is my sole responsibility to decide which forms of testing best aids me in protecting my health and specifically my breast health, and that it is not the responsibility of Mobile Thermographic Imaging or those associated with Mobile Thermographic Imaging.

*Initial*_____ I understand my screening will be performed by a Diagnostic Medical Sonographer, and will be monitored and submitted by a Registered Diagnostic Medical Sonogorapher for quality assurance, and a board-certified Radiologist will complete my written report based on my images. I agree my ultrasound report will be emailed directly to me from MTI approximately within two (2) weeks of my screening, and that my report will include written results of the findings but will not include images, however a disc of my images may be requested by my physician. I understand and agree that the report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment, and that the report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the report will be an analysis of the images with respect only to the ultrasound findings discussed in the report.

*Initial*_____ In the event the Radiologist identifies potential abnormal findings, I have been informed that I will be notified by MTI and advised to consult with my physician immediately. By signing this acknowledgement, I agree to contact my physician for further diagnostic evaluation in the event abnormal findings are identified, and that it is my complete sole responsibility to follow up with my doctor thereafter. I further agree that if I experience any symptoms after my screening, regardless if my screening was considered normal, I will contact my physician immediately.

*Initial*_____ I understand ultrasound screening tests are intended to detect abnormalities in apparently healthy people that carry no risks, and that no health evaluation is perfect, nor is any breast test or screening a 100% accurate, and that false positives can occur with any type of screening test. I understand that age, breast structures, body habitus or other circumstances may limit the ability to detect all abnormalities and result in a false negative. I understand good breast health requires my participation in regular physician-guided examination and following recommended radiographic evaluations such as mammography and breast MRI, and that a multi-modal approach (multiple types of breast testing such as adding Thermography and Ultrasound to my regular breast care regimen) may increase my chances of early detection of abnormalities. I acknowledge Mobile Thermographic Imaging makes no guarantee and I shall not hold Mobile Thermographic Imaging liable if the screening exam fails to identify an abnormality.

*Initial*_____ By signing this acknowledgement I am fully aware that MTI provides a free phone consultation session with a Registered Sonographer and not a physician. I understand that the consultation session will not review any diagnosis or treatment recommendations, rather the session is simply explaining what the radiologist has stated in the report. I understand and agree that the sonographer will not make decisions on my behalf and is not to be held responsible for any decision I make after reviewing my report, and that any further testing, evaluation, and explanations should be deferred to my doctor.

In 2016, the U.S. Preventative Task Force guidelines for breast cancer screening are as follows: The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years. Biennial screening mammography is recommended for women ages 50-74.

By signing below, I certify and acknowledge that I have read, understand and agree with the before mentioned statements, that all questions have been answered to my satisfaction, and consent to the ultrasound examination. I further acknowledge that upon my request I may receive a copy of the Notice of Privacy Practices, and that all records, including but not limited to videotapes, scans, film, and tracings created with this ultrasound screening service are the sole property of Mobile Thermographic Imaging. I verify my information is correct and I understand that I am responsible and agree to pay for my entire bill for the services rendered to me by Mobile Thermographic Imaging.

CLIENT SIGNATURE _____ **DATE** _____

PRINT NAME _____

HEALTH HISTORY AND SYMPTOMS INFORMATION

This information is confidential. Please list your health history & symptoms pertaining only to the areas that are being scanned.

CLIENT NAME: _____ **DATE OF BIRTH:** _____

PREVIOUS HEALTH PROBLEMS: _____

PREVIOUS SURGERIES (LIST DATE OF SURGERIES): _____

CURRENT HEALTH PROBLEMS: _____

CURRENT MEDICATIONS: _____

OTHER TREATMENT: _____

LIST AREAS OF PAIN OR CONCERNING SYMPTOMS: _____

CLIENT SIGNATURE _____ *DATE* _____

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CONFIDENTIAL BREAST QUESTIONNAIRE

CLIENT NAME: _____ **DATE OF BIRTH:** _____

		YES	NO
1.	Any close relative or family member(s) who have had breast cancer?	☐	☐
2.	Ever been diagnosed with breast cancer?	☐	☐
3.	Ever been diagnosed with breast disease? (i.e. fibrocystic)	☐	☐
4.	Ever had any biopsies or non-cosmetic surgeries to your breasts?	☐	☐
5.	Ever had any cosmetic surgery or implants?	☐	☐
6.	Have you had a mammogram in the past 12 months?	☐	☐
7.	Have you had a mammogram in the past 5 years?	☐	☐
8.	Any abnormal results from breast testing?	☐	☐
	If YES, please describe: _____		
9.	Ever taken a contraceptive pill for more than 1 year?	☐	☐
10.	Ever suffered from cancer of the womb?	☐	☐
11.	Ever had hormone replacement therapy?	☐	☐
	If **YES, please check one:** ☐ Pharmaceutical ☐ Bio-Identical		
12.	Do you have an annual physical examination by a doctor?	☐	☐
13.	Do you perform monthly breast self-examinations?	☐	☐
14.	Did your period start before the age of 12?	☐	☐
15.	Did your period end after the age of 50?	☐	☐

16. Please estimate the total number of mammograms you have had. _____
Your age at first mammogram: _____

17. Number of children you have given birth to: _____ Your age at the birth of your first child: _____

18. Do you smoke? **Please check one:** ☐ Yes ☐ Never ☐ Not in the Last Year ☐ Not in the Last 5 Years

***I stopped smoking _____ years ago.**

19. Have you had a hysterectomy? **Please check one:** ☐ No ☐ Partial ☐ Complete

***Your age at the time of your Hysterectomy: _____**

HAVE YOU RECENTLY HAD ANY OF THESE SYMPTOMS? (CHECK EACH BREAST THAT APPLIES)

	RIGHT	LEFT
PAIN	☐	☐
TENDERNESS	☐	☐
LUMPS	☐	☐
CHANGE IN BREAST SIZE	☐	☐
AREAS OF SKIN THICKENING	☐	☐
SECRETIONS OF THE NIPPLE	☐	☐

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PLEASE ELABORATE ON ANY BREAST CANCER HISTORY, BIOPSIES OR BREAST DISEASE IN THIS AREA INCLUDING BUT NOT LIMITED TO THE TYPE OF CANCER, DATE DIAGNOSED, DATE BIOPSIED, LOCATION OF BIOPSY, RIGHT OR LEFT BREAST, LOCATION OF THE MASS, TREATMENTS, ETC:

_____

_____

_____

_____

_____

_____ _____

CLIENT SIGNATURE *DATE*

SELF-PAY CLIENT PAYMENT AGREEMENT & FINANCIAL POLICY

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 Mobile Thermographic Imaging (aka MTI); and that the charges presented to me are due in full on the day of service, unless previous arrangements have been made with the accounting department; and that these charges are solely in relation to professional services provided by MTI and the interpreting Radiologist; and that all other testing such as mammography, blood labs or follow up physician visits are not related to MTI and are my sole responsibility; and that the charge for this scan does not include any other additional scans.

INSURANCE: I understand that MTI does not file for or assist with insurance reimbursement and cannot provide any CPT Codes or Diagnosis Codes; and that if ultrasound is covered under my insurance policy, it is my sole responsibility to file and obtain reimbursement from my insurance company and that it still is not a guarantee of coverage. Flexible Spending Account, Health Savings Account and Aflac have accepted and reimbursed ultrasound, this however is not a guarantee of coverage. If requested, you will be provided with a basic receipt of payment and description of the service rendered.

DEPOSIT: I understand that a deposit is required for certain types of scan appointments. This deposit is non-refundable if I cancel in less than 48 hours and that a new deposit will be required upon rescheduling my appointment.

The Client certifies that he or she has read and agreed to the forgoing, and if requested, has received a copy thereof, and is the client or the client's representative and accepts its terms.

_____ _____

SIGNATURE OF CLIENT OR CLIENT'S AUTHORIZED REPRESENTATIVE **DATE**

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:** _____

PHONE NUMBER: _____ **EMAIL:** _____

As required by the Privacy Regulations, Mobile Thermographic Imaging may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize **Mobile Thermographic Imaging** to use and disclose my Client Health Information to **the interpreting Radiologist.**

Client/Patient Health Information authorized to be disclosed: Ultrasound Images and related health history for the specific purpose of interpretation of said images.

This authorization form will expire in one year. Medical records are only kept for seven years. In order to keep the client's file updated, Mobile Thermographic Imaging provides the client with a new Authorization form to sign each year.

I understand I have the right to:

- 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.
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
- Inspect a copy of Patient Health Information being used or disclosed under federal law.
- Receive a copy of this authorization.
- 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.

CLIENT/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 diagnose or tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the ultrasound findings discussed in the Report. I understand that ultrasound is not the same as and does not replace mammography, blood labs or any other forms of testing. I understand that it is my responsibility to decide which forms of testing best aids me in protecting my health and particularly my breast health and is not that of Mobile Thermographic Imaging or those associated with Mobile Thermographic Imaging. By signing below, I certify that I have read and understand the statements above and consent to the examination. I verify my information is correct and I understand I am responsible for my bill.

_____ _____

SIGNATURE OF CLIENT OR CLIENT'S AUTHORIZED REPRESENTATIVE **DATE**

_____ _____

AUTHORIZED SIGNATURE OF FACILITY/TECHNICIAN **DATE**

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