DATE: _____

LOCATION: _____

REGIONS SCANNED: _____

THERMOGRAPHER: _____

CLIENT INFORMATION

CLIENT 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.): _____

REPORT PREFERENCES

Your report will be emailed within 2-3 weeks from date of scan. There is an additional $5 fee for mailed reports.

$50 RUSH REPORT: Please Initial _____ if you would like your report RUSHED for an additional $50 and emailed to you within 24 - 48 business hours.

LOCATION COPY: Please Initial _____ if you are a patient of the doctor at this location and would like a copy sent to him/her at no additional charge.

$5 MAILED REPORT: Please Initial_____if you would like to have your report mailed to you for an additional $5.

$5 ADDITIONAL COPY: Please Initial _____ if you would like your report sent to another physician*.

***PLEASE PROVIDE THE PHYSICIAN'S NAME, MAILING ADDRESS OR EMAIL ADDRESS:**

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN EMAIL ADDRESS: _____

CLIENT 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 thermographic findings discussed in the Report. I understand that thermography is not the same as and does not replace mammography, ultrasound, 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 (aka MTI) or those associated with MTI. 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.

_____ _____

CLIENT SIGNATURE **DATE**

HEALTH HISTORY AND SYMPTOMS INFORMATION

This information is confidential. Please list your health history and symptoms.

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

PREVIOUS HEALTH PROBLEMS: _____

_____

_____

PREVIOUS SURGERIES (LIST DATE OF SURGERIES): _____

_____

_____

CURRENT HEALTH PROBLEMS: _____

_____

_____

CURRENT MEDICATIONS: _____

_____

OTHER TREATMENT: _____

_____

FAMILY HEALTH HISTORY: _____

_____

(FULL BODY CLIENTS ONLY)

LIST AREAS OF PAIN: _____

_____

_____

_____ _____

CLIENT SIGNATURE **DATE**

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 CIRCLE:** 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 CIRCLE:** No Partial Complete Age at Time of 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	☐	☐

_____ _____

CLIENT SIGNATURE **DATE**

EXTENDED BREAST QUESTIONNAIRE

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

DIAGNOSED WITH BREAST CANCER

CANCER TYPE: Metastatic ☐ Local ☐ Lymph Node Involvement ☐ Unknown ☐

WHEN DIAGNOSED: Month _____ Year _____

PLEASE CIRCLE THE LOCATION OF BREAST: UO (UPPER OUTER), UI (UPPER INNER), LO (LOWER OUTER), LI (LOWER INNER)

LEFT BREAST: UO ☐ UI ☐ LO ☐ LI ☐ NIPPLE ☐ OTHER ☐

RIGHT BREAST: UO ☐ UI ☐ LO ☐ LI ☐ NIPPLE ☐ OTHER ☐

TREATMENT: Surgery ☐ Chemo ☐ Radiation ☐ Other ☐ None ☐

DIAGNOSED WITH OTHER BREAST DISEASE (Please report other types of disease in history.)

DISEASE TYPE: Fibrocystic ☐ Cystic ☐ Mastitis ☐ Abscess ☐ Other ☐

BREAST BIOPSIES OR SURGERY

DATE OF BIOPSY(IES) & DETAILS: _____

_____

_____

PLEASE CIRCLE THE LOCATION OF BIOPSY(IES): UO (UPPER OUTER), UI (UPPER INNER), LO (LOWER OUTER), LI (LOWER INNER)

LEFT BREAST: UO ☐ UI ☐ LO ☐ LI ☐ NIPPLE ☐ OTHER ☐

RIGHT BREAST: UO ☐ UI ☐ LO ☐ LI ☐ NIPPLE ☐ OTHER ☐

_____ _____

CLIENT SIGNATURE **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 **EMI, Electronic Medical Interpretations (the interpreting of doctors.)**

Client/Patient Health Information authorized to be disclosed: Thermal 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.

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_____ _____

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

_____ _____

AUTHORIZED SIGNATURE OF FACILITY/THERMOGRAPHER **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 by Electronic Medical Interpretations (aka EMI, the interpreting physicians); and that all other testing such as mammography, ultrasound, blood labs and the like that are suggested by the interpreting physician are not related to MTI and are my sole responsibility; and that there are separate and different charges for my initial scan, my baseline scan and my annual scan, and that the charge for my initial 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 thermography 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 thermography, this however is not a guarantee of coverage. United Breast Cancer Foundation's Breast Screening Program offers a grant for uninsured, underinsured and low-income women and men to receive a low-cost breast screening. Visit www.UBCF.info for details.

DEPOSIT: I understand that a deposit is required for certain types of thermography scan appointments and that this deposit is nonrefundable if I cancel in less than 24 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**

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_____ _____

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