BREAST PATIENT INFORMATION SHEET
DFW

Name: _____ Date of birth _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Occupation: _____ Age _____ Gender (M/F) _____

Primary Care Physician: _____

Referring Physician: _____

Clinical concerns/ Main complaint:

Current symptoms and how long you have had each symptom. Made worse by or Made better by

Current treatment (if any):

Current Medication:

(Office use only) Previous thermogram date: Previous Report #

Surgery	Year	Surgery	Year	Surgery	Year

Dental History: (ex: implants upper left, root canals lower right, dentures, amalgam fillings, gum disease, etc...)

General History: (accidents, injuries, fractures, diseases, smoking/ chemical exposures, high risk issues, etc...)

Family history:	Relationship:	Family history:	Relationship:	Family history:	Relationship:

(Office use only) Diagnoses:

(Office use only) Skin lesions or Physical abnormalities:

(Female patient only) – Ob/Gyn Hx:

Date (year) of most recent mammogram:_____Result:_____

(Office use only) Notes:

We can either email a copy of your report or we can send one via the post office. Which would you prefer. Please check **ONE**. Email it to me:_____Mail it to me:_____Both + $10 fee_____

Do you want a copy of the thermogram report and images forwarded to your doctor? _____

If yes, please provide your doctor's name and address (addresses from an internet search are not always accurate – **please** confirm the correct mailing address for **your** doctor's office).

Doctor:

_____

_____

This information is confidential. All information is correct to the best of my knowledge.

Signed:_____Date:_____

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

Name:_____Date of Birth:_____

	Yes	No
1. Do you have any close relative who has had breast cancer?	____	____
2. Have you ever been diagnosed with breast cancer?	____	____
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	____	____
4. Have you had any biopsies or surgeries to your breasts?	____	____
5. Have you had any breast 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. Have you had abnormal results from any breast testing?	____	____
9. Have you ever taken a contraceptive pill for more than 1 year?	____	____
10. Have you suffered with cancer of the womb?	____	____
11. Have you had pharmaceutical hormone replacement therapy?	____	____
12. Do you have an annual physical examination by a doctor?	____	____
13. Do you perform a monthly breast self exam?	____	____
14. Did your periods start before the age of 12?	____	____
15. Did your periods finish after the age of 50?	____	____

16. How many mammograms have you had in total? _____

15. What was your age when you had your first mammogram? _____

16. How many children have you given birth to?_____ Your age at birth of first child:_____

17. Do you smoke? Currently_____ Never_____ Not smoked in Last Year_____Not smoked in Last 5 Years_____

19. First date of your last menstrual cycle: _____

Have you *recently* had any of these breast symptoms:

Pain	**___ right**	**___left**
Tenderness	**___ right**	**___left**
Lumps	**___ right**	**___left**
Change in breast size	**___ right**	**___left**
Areas of skin thickening or dimpling	**___ right**	**___left**
Secretions of the nipple	**___ right**	**___left**

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 discussed in the Report.

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

Signature ..... Today's date _____

Authorization to Use or Disclose Protected Health Information

DFW Thermography

Patient Name:_____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, DFW 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

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*

DFW 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.

This notice applies to all of the records of your care generated by the practice, whether made by the practice or an associated facility. This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION
We will routinely use your medical information inside our office for these purposes without any special permission:

Treatment – Our practice may use and disclose your medical information to treat you.
Payment – We may use and disclose your medical information in order to bill and collect payment for services.
Health care operations – Our practice may use and disclose your medical information to operate our business.

In addition, we may use or disclose your medical information for the following reasons:

Appointment reminders – Our practice may use and disclose your medical information to contact you and remind you of an appointment.
Treatment options and health-related benefits – To inform you of potential treatment options or services that may be of interest to you.
Disclosures required by law – Our practice may use and disclose your medical information when we are required to do so by federal, state, or local law.
Health oversight activities – Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary action, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
Lawsuits and similar proceedings – If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office.
Serious threat to health/safety – We may use or disclose your medical information when it is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
Involvement in individual's care – We may disclose your medical information about you to a family member, close personal friend or other person identified by you if directly relevant to that person's involvement with your care or payment related to your health care.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your rights include but are not limited to the following:
Confidential communications. You have the right to request that we communicate with you in certain ways. DFW Thermography will accommodate reasonable requests.
Inspection and copies of records. With limited exceptions, you may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. This request must be made in writing and you may be charged a fee for the costs of copying, mailing, and other costs incurred by us in complying with your request.
The right to request amendments to your information. You may request an amendment of protected health information about you as long as we maintain this information. Requests must be made in writing and must be directed to the office manager.
Disclosures. You have the right to a detailed list of all disclosures our practice has made of your medical records.
Paper copy or complaints. You have the right to a paper copy of this notice and the right to file a complaint with the office manager if you feel that your privacy rights have been violated at any time.

I have received a copy of DFW Thermography's Notice of Privacy Practices.

_____ _____

Signature Date