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Improving all aspects of Your Health

360 Thermography Patient Information Sheet

Name ____ Date of Birth__________________

Mailing Address____

City ____State ________________Zip Code___________

Email address ____

Phone (H) __________________________ (W) _______________________(C) __________________________

Occupation ____

Previous Illnesses: ____

____

Previous Surgery ____

____

Current Health Problems ____

____

Medications: ____

____

Other Treatment ____

Current Doctor ____

Do you want a copy of the thermogram report forwarded to your doctor? ______________________________

If yes, doctor's name and address____

____

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

Signed_____________________________________ Date _____________________

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAINNAIRE

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name:____**Birthdate:**________________________

	Question	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 been diagnosed with any other breast disease (fibrocystic)?		
4.	Have you had any biopsies or surgeries to your breast?		
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 any abnormal results from any breast testing?		
9.	Have you ever taken a contraceptive pill for more than one 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. How many mammograms have you had in total? ___________________________
15. What was your age when you had your first mammogram? ___________________
16. How many births have you had? ____
17. Your age at birth of first child? ____
18. Do you smoke? Yes: ________ Never:_________ Not in last 12 months:________ Not in last 5 years:_________
19. Age at first period ______ Age at last period______

Have you recently had any of these breast symptoms:

Symptom	Right	Left
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions from nipple		

EXTENDED BREAST QUESTIONNAIRE

Patient Name: ____ Date: ________________________

Diagnosed with Breast Cancer:

Cancer Type: Metastatic ____ Local ____ Lymph Node Involvement ____

Diagnosis date: Month ___________ Year __________

Where (left breast): UO ____ UI ____ LO ____ LI ____Nipple ____

Where (right breast): UO ____ UI ____ LO ____ LI ____Nipple ____

Treatment: Surgery ____ Chemo ____ Radiation ____Other ____ None ____

Diagnosed with other Breast Disease:

Disease Type: Fibrocystic ____ Cystic ____ Mastitis ____ Abscess ____ Other ____
(Please report other types of disease in the history.)

Breast biopsies or Surgery:

Where (left breast): UO ____ UI ____ LO ____ LI ____Nipple ____

Where (right breast): UO ____ UI ____ LO ____ LI ____Nipple ____

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Russell Canfield MD, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Russell Canfield MD, PC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Russell Canfield MD, PC reserves the right to revise its Notice of Privacy Practices at any time. To obtain a revised Notice of Privacy Practices, send a written request to Russell Canfield MD, PC.

With this consent, **Russell Canfield MD, PC may call** my home or an alternative location and leave a message on voice mail or with a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, clarifying insurance information and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Russell Canfield MD, PC may mail or e-mail** to my home or an alternative location these and other items that assist the practice in carrying out TPO.

With this consent, **Russell Canfield MD, PC may disclose my PHI to other health care providers involved in my care** for purposes related to my medical treatment.

Your protected health information may be disclosed in the form of a "limited data set" for research, public health, and health care operations. A "limited data set" does not contain any direct identifiers of individuals (e.g. should not include name, address, phone number, social security number, etc.), but may contain any other demographic or health information needed for public health research or health care operations purposes.

I have the right to request that Russell Canfield MD, PC restrict how it uses or discloses my PHI in carrying out TPO.

By signing this form, I am consenting to allow Russell Canfield MD, PC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent.

____ _____________

Signature of Patient or Legal Guardian, if applicable *Date*

____

Print Name of Patient or Legal Guardian

Authorization to Use or Disclose Protected Health Information

Patient Name: ____

Address: ____

Date of Birth: _______________________ Date of Request: ___________________

As required by the Privacy Regulations, 360 Medicine 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**: Interpretation of said images**

Effective dates for this authorization: _________________ through _________________

This authorization will expire at the end of the above period.

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.

Refuse to sign this authorization.

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.

____ ____________________

Signature of Patient or Patient's Authorized Representative *Date*

____ ____________________

Authorized Signature of Facility *Date*

CONSENT TO USE MEDICAL IMAGES AND HISTORY

1. I, ……………………………………. do hereby give perpetual permission to Meditherm and its affiliates to use my images, case history and any supporting documentation in case reviews, peer review and advertising **provided that**:
    a. My identity is not directly or indirectly disclosed (except in confidentiality to the peer review board).
    b. Sufficient case matter is quashed to protect my identity as necessary.
    c. Meditherm and I jointly own copyright to material supplied by myself, and copyright can not be inferred onto other entities without my express written permission.
    d. The information supplied shall not be used to cause harm or defame to any other person or profession.

2. Should these stipulations be breached, this consent is to be considered immediately revoked and all materials relevant to my case returned or destroyed.

3. Signed ………………………………………………. Dated …………………………….....

<u>How your images, documents and history may be used.</u>

Meditherm as a member of the American College of Thermology Inc., is currently compiling a database of case studies for use in future statistical analysis, case studies for teaching purposes, correlation studies and an image base for publicity and public education with known, accurate case histories.

Your identity (including information that could be suspected of leading to your identity) remains completely confidential, with only the case reviewers of the ACCT having access to your name (to verify any facts regarding your case).

No other organization will have access to your records or will approaching you directly for further information or soliciting you for any further studies. Any copies of test results etc. that are passed on to us as a part of your case study will be edited to remove your name, address and any other contact or identity details before being used further.

Should you be asked to be a part of an ongoing study by us, all further imaging that forms a part of that study will of course be without charge as a thank you for your co-operation.

We thank you for your help. Your contribution is very much appreciated and not taken for granted.

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.

Patient Signature ____Date:_________________