THERMOGRAPHY OF HOUSTON

SCREENING ULTRASOUND REGISTRATION FORM

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

Full Name: _____
First Middle Last

Date of Birth: _____ Cell: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State:_____ Zip: _____

Email Address: _____

BREAST EXAMS ONLY:

Is this exam due to an abnormal mammogram? YES or NO

If yes, please bring in any previous reports or discs with images you have to your appointment

Have you ever been diagnosed with breast cancer? YES or NO

If yes, please elaborate on any breast cancer history, biopsies, the type of cancer, date diagnosed, date biopsied, location of biopsy, location of the mass or lump, treatments, etc. Please bring in any previous reports or discs you have to your appointment.

_____

_____

ALL EXAMS – REASON FOR THIS APPOINTMENT:

Provide a brief history of the reason for your exam today including any current or previous health issues specific to the area we are examining.

_____

_____

SURGICAL HISTORY:

_____

_____

Have you had an ultrasound of this same area before? YES or NO

***If YES**, continue to next question*

Was your previous exam done with our company? YES or NO

***If NO**, please bring a copy of your previous report and/or disc with images to your appointment for us to upload to the Radiologist for comparison)*

Allergies:

List any allergies and PLEASE inform our staff if you have an allergy to Latex.

_____

A copy of your report will be provided to you. If you would like a disc with your images, they are available at a cost of $10 per disc. Would you like a copy of your images sent to you? _____ Quantity? _____

I verify the accuracy of the information above. I authorize Thermography of Houston to furnish any medical information requested and to release this questionnaire and the images from my scan to Vesta Teleradiology for interpretation. I understand that I am financially responsible for the charges related to this ultrasound examination.

_____ _____

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

ACKNOWLEDGEMENT & CONSENT FORM - SCREENING ULTRASOUND

I hereby authorize Thermography of Houston, LLC (hereby referred to as "TOH") to perform an ultrasound screening. In requesting this, I understand that this is a screening test only and the results do not in any way constitute a medical diagnosis. These screening tests do not substitute for regular health care or a physician exam.

I understand my screening will be performed by and/or overseen by a Registered Diagnostic Medical Sonographer. A board-certified Radiologist will review your screening images and the written results will be emailed directly to you from TOH within approximately one week of your appointment. I understand ultrasound reports include written results of the findings but no images. A disc of the images may be requested by your physician. If the Radiologist identifies potential abnormal findings, you will be notified by our office and advised to consult with your physician immediately. By signing this acknowledgement, you agree to contact your physician for further diagnostic evaluation in the event abnormal findings are detected. It is your complete responsibility to follow up with your doctor in the even abnormal findings are detected.

By signing this acknowledgement, I am fully aware that any consultation with a staff member or technician at TOH is not a physician. I understand and agree that the staff member or technician will not make decisions on my behalf and is not to be held responsible for any decision I choose to make after reviewing my report, and that any further testing, evaluation, and explanations should be deferred to my doctor.

I understand screening tests are intended to detect abnormalities in apparently healthy people and carry no risks. However, no health evaluation is perfect and no breast testing or screening is 100% accurate. False positives can occur with any type of screening test. Age, breast structure, body habitus, or other circumstances may limit the ability to detect all abnormalities and result in a false negative. 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 age 50-74.

I understand good breast health requires participation in regular physician-guided examination and recommended radiographic evaluations such as mammography and breast MRI. A multi-modal approach (multiple types of breast testing, such as adding thermography and ultrasound to your regular breast care regimen) may increase your chances of early detection of abnormalities. TOH makes no guarantee and shall not be liable if the screening exam fails to identify an abnormality. If you experience any symptoms, consult your physician immediately regardless of a normal screening.

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 TOH or those associated with TOH.

Client consent for use and disclosure of protected health information:

I hereby give my consent for Thermography of Houston, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

Thermography of Houston, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Thermography of Houston, LLC at 13644 Breton Ridge Street, Suite E, Houston, TX 77070.

ACKNOWLEDGEMENT & CONSENT FORM - SCREENING ULTRASOUND (continued)

With this consent, Thermography of Houston, LLC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care. No test results, however, will be left on voicemail or with any person without a specific request by me to do so.

With this consent, Thermography of Houston, LLC may email or mail to home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that Thermography of Houston, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Thermography of Houston, LLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Client pre-exam acknowledgement:

With regards to my examination, I understand that I may be required to remove certain garments and wear a hospital gown. I also understand that the technologist performing my exam must maintain a close proximity to me during the examination and must engage in contact with the area to be examined to satisfy the logistical requirements for successful completion of the exam. I understand that this is necessary and will be executed in a strictly professional manner with respect to my dignity and privacy. I waive any liability to Thermography of Houston, LLC should I suddenly find objection to this during my examination.

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. 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.

_____

PRINTED NAME OF PATIENT

_____ _____

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

PAYMENT AGREEMENT & FINANCIAL AGREEMENT
SELF-PAY SCREENING CLIENT

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 Thermography of Houston, LLC (TOH); and that the charges presented to me are due in full prior to my appointment, unless previous arrangements have been made with the accounting department; and that these charges are solely in relation to professional services provided by TOH and the interpreting Radiologist; and that all other testing, such as mammography, blood labs, or follow-up physician visits are not related to TOH and are my sole responsibility; and that the charge for this exam does not include any other additional exams.

INSURANCE: Since this is a screening exam (exam performed without doctor's orders), I understand that TOH does not file for or assist with insurance reimbursement and cannot provide any CPT codes or diagnostic codes; and that is ultrasound is covered under my insurance policy, it is my sole responsibility to file and obtain reimbursement from my insurance company and this it still is not a guarantee of coverage. Flexible Spending Account, health Savings Account and Aflac have accepted and reimbursed for various health screenings, 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.

CANCELLATIONS: You may cancel or reschedule 48 hours prior to your appointment and receive a refund of your payment. Cancellations made within 48 hours of your appointment are non-refundable.

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**