Name: _____D.O.B. _____

Address: _____

Phone: _____ E-mail: _____

Occupation: _____ How did you hear about us:_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

Please note: It is our policy to not provide thermography if you are pregnant, or are breastfeeding. We can provide thermography 90-days post-partum and/or lactation.

I understand that **Whole Health Thermography, LLC** does not provide a medical diagnosis, but simply acts as the clinical thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. A medical doctor will interpret the images, write a report and return the images to **Whole Health Thermography, LLC.** This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider.

I give my permission for the clinical thermographer at **Whole Health Thermography, LLC** to take and submit DITI pictures for interpretation. I understand that by doing so, the clinical thermographer is not becoming my primary care physician. I understand that a set of thermography pictures and the medical report will be e-mailed to me so that I can share with my health care practitioner, primary care doctor, or anyone of my choosing. I understand that a doctor-to-doctor consultation can be arranged between Medi-Therm and my doctor if necessary.

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.

Referring Physician's Name (*if applicable*): _____

Client Signature_____ Date_____

Thermographer's Signature_____ Date_____

Whole Health Thermography, LLC *clinical thermographers are trained and certified by the ACCT.*

Authorization to Use or Disclose Protected Health Information

As required by the Privacy Regulations, **Whole Health Thermography, , LLC,** 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 Client Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Client 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 that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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 in the use or disclosure pursuant to this authorization.
2. Have 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 Client's Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization, however by doing so, we will not be able to provide thermographic services.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected client health information.

_____ _____
Signature of Client or Client's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

Cancellation and Reschedule Policy

• We understand that life happens and sometimes you are unable to keep your scheduled appointment. In these instances, we would greatly appreciate your courtesy call at least 24 hours in advance of your appointment time, so that we can plan accordingly. This consideration allows other clients an opportunity to reserve an appointment during that time. Because of the distance that we often travel to provide service to our remote clinics, your advance notice also assures that we plan our staffing and materials requirements properly.
• If you do not appear for your scheduled appointment and you have not contacted us via phone, text or email we reserve the right to charge a cancellation fee equal to the cost of your booked service.
• If you are running late for your appointment, please call us. We will do our best to accommodate you or reschedule your appointment.
• We are dedicated to making your screening appointments as easy and convenient as possible. We thank you for your understanding of this important issue.

Age / Gender:
Primary Care Physician: Referring Physician:

NEW CLIENTS: *complete entire form.* ***RETURNING CLIENTS:*** *detail any changes and or updates.*

Clinical Concerns (*Dysfunction and or diagnosis reported by a practitioner)*

Current Symptoms (*What you're feeling or experiencing)*

Current Treatment (*I.e.- chiropractic, acupuncture, IV therapy, red light therapy)*

Current Medication & Supplements used medicinally	***Taken For***	***Date Started***	***Recent dosage changes***

Thermogram Hx:
Result of any clinical assessment/testing done after your previous Thermogram:

Date	***Type of Surgery***	***Comments***

Date	***Amalgams, Extractions, Implants, Root Canals***	***Tooth location or approximate location***

Date	*Past traumas, illness, injuries, diseases*	*Comments*

Family Hx (*Cancer in Grandparents, Parents, Siblings, Children)*

Diagnoses (*past & current, approximate dates)*

Skin Lesions Or Physical Abnormalities (*include scars from injury, surgical scars, current skin irritation, tattoos or piercings*)

Recent Vaccines	*Date & Arm*	*Symptoms*

(Female Patient Only)
Ob/ Gyn Hx (*include all genitourinary hx, pregnancies, births, breastfeeding)*

Mammogram/ Ultrasound Hx (*approximate date & summary of findings*)