The Health Insurance Portability and Accountability Act (HIPAA)

Authorization to Use or Disclose Protected Health Information

The Hills Medical Group

Name:_____

As required by the Privacy Regulations, **The Hills Medical Group** may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize **The Hills Medical Group** 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 to EMI:
Thermal images and related health history for the purpose of thermographic interpretation.

This authorization is effective from (today's date) _____/_____/_____.

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 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 of Client or Client's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

The Hills Medical Group
4201 Bee Caves Road, Suite B112, West Lake Hills, Texas 78746
Phone: 512-327-4886

The Hills Medical Group

AGREEMENT FOR SERVICES

I _____ fully understand the following:
[Please print your name.]

* Digital Infrared Thermal Imaging (DITI / Thermal Screening / Thermography) does not diagnose or treat any disease or health condition. If I have any disease or health condition, I must seek qualified medical advice from a licensed health care professional.

* The Hills Medical Group is dedicated to helping its clients find a path to better health with an emphasis on education and self-care. My interest is to educate myself in achieving the best health possible.

* DITI is an adjunctive screening and is not designed to replace other screening methods.

* DITI, like a mammogram or sonogram, is not 100% definitive. DITI results may suggest the need for other diagnostic tests. A suspicious mass may warrant a biopsy.

* I have chosen DITI for one or more of the following reasons:

_____ 1. I wish to minimize my exposure to radiation.
_____ 2. I am looking for methods of possible earlier detection of health abnormalities.
_____ 3. I do not desire to have a mammogram.
_____ 4. I have had a mammogram before and choose not to have another one.
_____ 5. I have mammograms and desire to include DITI as an adjunctive procedure.
_____ 6. Other (explain) _____

* Thermal Breast Screening is especially appropriate for younger women between 25 and 50 whose denser breast tissue makes it more difficult for mammography to pick up suspicious lesions. DITI can provide a “clinical marker” that a specific area of the breast needs further examination and/or close monitoring.

* What I learn from The Hills Medical Group and DITI may not be universally accepted. Certain agencies and other health authorities may not agree with an approach where the client must be responsible for developing and maintaining his or her own health care.

* I give consent to the use of my images, provided that my personal information is held in the strictest of confidentiality. Yes _____ No _____ (*Please initial one*.)

* The reports/images provided are not designed for self-diagnosis and should be reviewed by a health care professional.

I have read and understand what is printed above.

Signature: _____ Date: _____

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BREAST THERMOGRAPHY QUESTIONNAIRE

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

Name: _____

		Yes	No
1.	Do you have close relatives with a history of breast cancer?	☐	☐
2.	Have you ever been diagnosed with breast cancer?	☐	☐
3.	Have you been diagnosed with other breast condition(s)? (e.g. fibrocystic)	☐	☐
4.	Have you had biopsies or other breast surgery?	☐	☐
5.	Have you had 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 ever been diagnosed with uterine cancer?	☐	☐
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. How old were you when you had your first mammogram? _____
16. How many births have you had? _____ Your age at birth of first child: _____
17. Did your periods start before the age of 12? _____ Or end after 50? _____
18. Do you smoke? Please circle: Yes / Never / Not in last year / Not in last 5 years

Have you recently had any of these symptoms?	Right Breast	Left Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

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Please complete this section if you have been diagnosed with breast cancer:

Cancer type: Metastatic ☐ Local ☐ Lymph node involvement ☐

When diagnosed: Month _____ Year _____

Below: UO = Upper Outer; UI = Upper Inner; LO = Lower Outer; LI = Lower Inner

Where (left breast): UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

Where (right breast): UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

Treatment: Surgery ☐ Chemo ☐ Radiation ☐ None ☐
Other ☐ (explain) _____
_____

Please complete this section if you have been diagnosed with other breast conditions:

Disease type: Fibrocystic ☐ Cystic ☐ Mastitis ☐ Abscess ☐
Other ☐ (explain) _____
_____

Please identify areas of breast biopsies or surgery:

Where (left breast): UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

Where (right breast): UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

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 to the thermographic findings discussed in the report.

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

Signature _____ Today's date _____

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PATIENT INFORMATION
CONFIDENTIAL

Name: _____

Street / PO Box: _____

_____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

THERMOGRAPHY RESULTS will be sent in PDF format to the email address above.

Date of Birth: _____/_____/_____

Occupation: _____

Have you had other DITI / clinical thermography screenings? YES / NO.

Family Health History that could affect your health:

_____

_____

_____

Current Clinical Concerns & Symptoms:

_____

_____

_____

_____

_____

_____

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Current Medications:

Current Treatment (e.g. radiation, chiropractic, acupuncture, etc.):

Mammogram/Ultrasound History:

- Date of most recent exam(s): _____/_____/_____
- Results: _____

Breast Health:
Note any breast health concerns or history not noted elsewhere on the forms.

Ob/Gyn History:

Have you had root canals, crowns, braces, implants or other major dental work?

Diagnosed Conditions (e.g. diabetes, hyperthyroidism):

General History:
Include previous major illnesses and illnesses that affect your current health.
Include Surgical History not noted elsewhere on the forms:

Skin Markings:
Please note any skin lesions, tattoos or other skin markings visible in the area(s) of screening.

Is this your first Digital Infrared Thermal Imaging (DITI) screening? YES / NO

All information is correct to my knowledge.

Signed _____ Today's Date _____

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