THERMOGRAPHY OF HOUSTON

DIAGNOSTIC 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: _____

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

Home Phone: _____ Work Phone (optional): _____

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.

_____

Referring Physician Name: _____

Phone: _____ Fax: _____

*Thermography of Houston, LLC will automatically provide a report to your referring physician. Please contact their office to review your results.

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

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND PRE-EXAM ACKNOWLEDGEMENT

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.

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 my 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.

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.

_____

PRINTED NAME OF PATIENT

_____ _____

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

PAYMENT AGREEMENT & FINANCIAL POLICY
SELF-PAY DIAGNOSTIC PATIENT

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 this includes charges presented to me for both the deposit paid prior to the service and the remaining balance that is due in-full at the time of service, 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: TOH does not file insurance. If I have received a doctor's order for this exam, I will receive a detailed receipt to submit to my insurance. If ultrasound is covered by my insurance policy, it is my sole responsibility to file and obtain reimbursement from my insurance company and that it is still not a guarantee of coverage. Flexible Spending Account, Health Savings Account, and Aflac have accepted a reimbursed for various exams, this however is not a guarantee of coverage.

CANCELLATIONS: I may cancel or reschedule 48 hours prior to my appointment and receive a refund of my deposit. Cancellations made within 48 hours of my 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 PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE **DATE**