

Patient Intake Form

Name: _____

DOB: _____ Age: _____

Address: _____

City: _____ Zip: _____

Occupation: _____

Email: _____

Phone: (H) _____

(C) _____

(W) _____

For Office Use Only

Patient ID# _____ Report Ref# _____

Scan Type: _____ Scan Location: _____

Referred by: _____

Date of R&S submitted to EMI: _____

Date of R&S processed & sent to Patient: _____

Date Patient called regarding R&S findings: _____

Patient Receipt Sent: _____ Patient Report/Images Sent: _____

Doctor/Health Care Provider Patient Report/Images Sent: _____

Payment: _____ Cash _____ Check#: _____ CC: V MC D AE

Processing: Email, CD or Printed Followed Protocol: Yes No

Next Appt: _____ Notes: _____

Reason for today's visit: _____

Current Symptoms (SX): _____

Current Treatment (TX): _____

Previous Illnesses: _____

Previous Surgeries/Dates: _____

Previous Injuries/Dates: _____

Current Medication(s): _____

Thermography (HX): _____

Doctor or Health Care Provider's Email: _____

Contact person in case of emergency:

Name: _____ Phone: _____ Relationship: _____

This document is confidential and legally privileged. Any retention, dissemination, distribution or copying of this communication is strictly prohibited. All information is correct to my knowledge

Signature: _____ Date: _____

Lower Body Questionnaire

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

Please use the symbols below to indicate areas of:

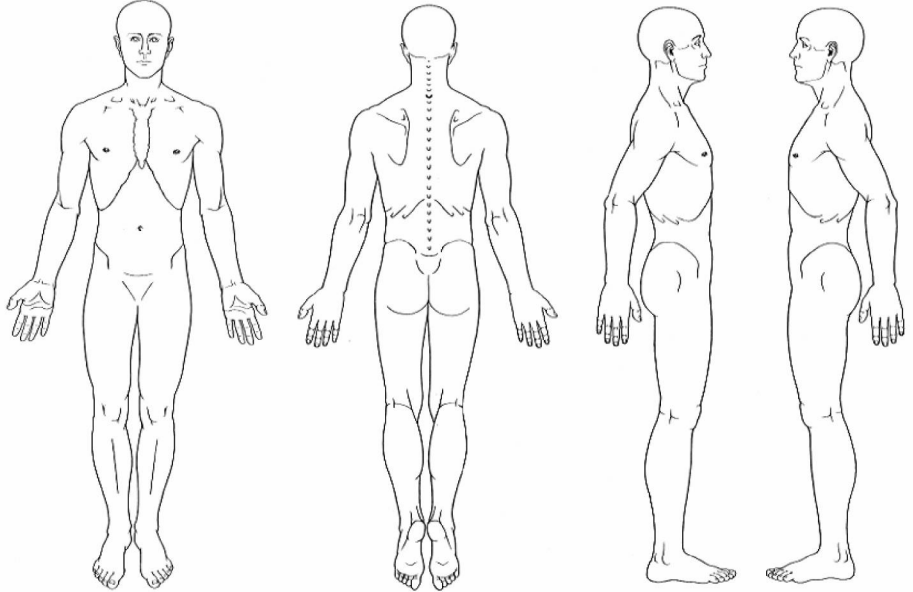
Main Pain: *

Secondary Pain: ^^

Numbness: /////

Pins and needles: :::::

Skin lesions / scarring: ###



Do you know what triggered the pain? _____

Does anything relieve it? _____

Does anything aggravate it? _____

Has it changed since it began? _____

Have you had any treatment? _____

Notes: _____

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.

Signature: _____ Date: _____

Breast Questionnaire

- | | | |
|---|-----|----|
| 1. Do you have any close relative who has had breast cancer? | Yes | No |
| 2. Have you ever been diagnosed with breast cancer? | Yes | No |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)? | Yes | No |
| 4. Have you had any biopsies or surgeries to your breasts? | Yes | No |
| 5. Have you had any breast cosmetic surgery or implants? | Yes | No |
| 6. Have you had a mammogram in the past 12 months? | Yes | No |
| 7. Have you had a mammogram in the past 5 years? | Yes | No |
| 8. Have you had abnormal results from any breast testing? | Yes | No |
| 9. Have you ever taken a contraceptive pill for more than 1 year? | Yes | No |
| 10. Have you suffered with cancer of the womb? | Yes | No |
| 11. Have you had pharmaceutical hormone replacement therapy? | Yes | No |
| 12. Do you have an annual physical examination by the doctor? | Yes | No |
| 13. Do you perform a monthly breast self exam? | Yes | No |
| 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? _____ Your age at birth of first child: _____ | | |
| 17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____ | | |
| 18. Do you smoke? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__ | | |

Have you recently had any of these breast symptoms: **Right Breast** **Left Breast**

Pain

Tenderness

Lumps

Change in breast size

Areas of skin thickening or dimpling

Secretions of the nipple

Notes: _____

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Signature: _____ Date: _____

Extended Breast Questionnaire

Patient Name: _____ Date: _____

Diagnosed with breast cancer:

Cancer type: Metastatic _____ Local _____ Lymph node involvement _____

When diagnosed: Month _____ Year _____

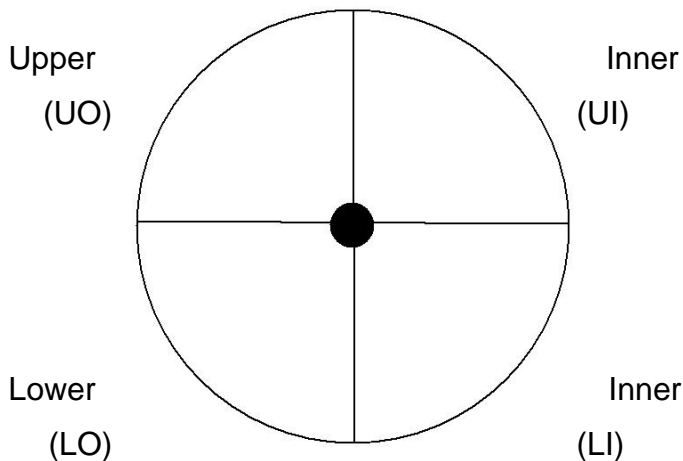
Where: Left Breast _____ Right Breast _____

Treatment: Surgery _____ Chemo _____ Radiation _____ Other _____ None _____

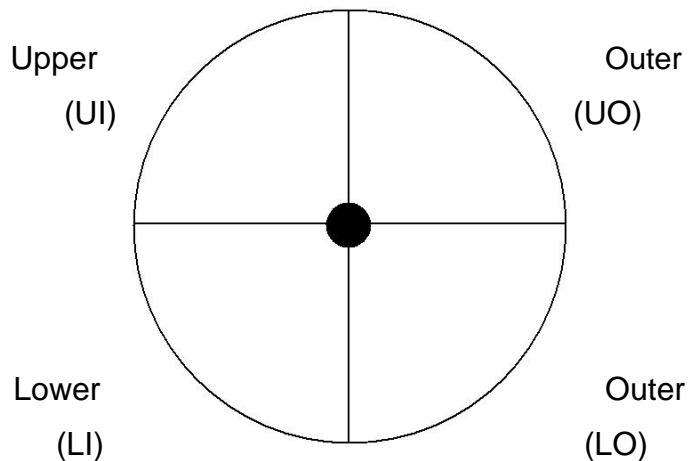
Other, please explain: _____

Breast biopsies or surgery: Please choose the area closest to the biopsy or surgery location based on the charts below. The exact location will be discussed and marked at your appointment. Extra scans will also be taken with a pointer to show the exact location for the doctor to review.

Left Breast



Right Breast



Where (left breast): UO _____

UI _____

LO _____

LI _____

Nipple _____

Where (right breast): UO _____

UI _____

LO _____

LI _____

Nipple _____

Diagnosed with other breast disease:

Disease type: Fibrocystic _____ Cystic _____ Mastitis _____ Abscess _____

Other, please explain: _____

(Please report other types of disease in the health history, thank you)

Patient Review of Body Systems

Constitutional

- Fevers/Chills/Sweats
- Unexplained weight loss/gain
- Fatigue/weakness
- Excessive thirst or urination

Musculo-Skeletal

- Muscle or Joint Pain
- Leg Pain with Exercise

Ears/Nose/Throat

- Difficulty hearing/ringing
- Hay Fever/Allergies

Cardiovascular

- Chest Pain/Discomfort
- Palpitations

Dental

- Extractions
- Crowns
- Root Canal
- Gum Disease
- Fillings
- Other _____

Respiratory

- Cough/Wheeze
- Difficulty Breathing

Gastrointestinal

- Heartburn/Reflux
- Nausea/Vomiting/Diarrhea
- Large bowel dysfunction

Skin

_____ Rash or Mole

Neurological

- Numbness
- Headaches

Organ Dysfunction

Blood/Lymphatic

- Unexplained Lumps
- Easy Bruising

Other

OB/GYN

- Pap Smear Results: Normal Abnormal (please explain) _____
- Hysterectomy - Date: _____ Bladder Infections: Yes No
- Birth Control: Yes No If Yes: _____ Type _____ Amount _____

General Medical History: Past and Current medical problems (please include dates)

- Heart Disease: (specify) _____
- High Blood Pressure High Cholesterol Diabetes
- Thyroid Problems Kidney Disease Asthma/Lung Disease
- Chemical Exposure Cancer: (specify) _____
- Other: (specify) _____

Family History: Please indicate the current status of your immediate family members

(Mother, Father, Sibling, Grandparent, Aunt, Uncle)

- High Cholesterol High Blood Pressure Other: _____
- Heart Disease Stroke _____
- Bleeding or Clotting Genetic Disorders _____
- Asthma/COPD Diabetes _____
- Cancer: (type) _____

Signature: _____ Date: _____

MIDNIGHT SUN HEALING NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Midnight Sun Healing is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice or associated with our practice for the purpose of treatment, payment or healthcare operations.

*“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers within or associated with **Midnight Sun Healing** for the benefit of providing you with more health care information.*

Payment

We email a receipt to you that can be sent to your insurance provider for the purpose of payment or health care operations.

*“As a courtesy to our patients, we email an itemized receipt for you to submit to your insurance carrier for the purpose of showing payment to **Midnight Sun Healing** for health care services rendered. The receipt contains our business information, your name and address, type of scan, price of scan, form of payment and date of service. If more information is needed please call our office at 920.660.3320 and we will be happy to assist you.*

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership.

In the event that **Midnight Sun Healing** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Midnight Sun Healing** is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that **Midnight Sun Healing** amend your protected health information. Please be advised, however, that **Midnight Sun Healing** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by **Midnight Sun Healing**.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Midnight Sun Healing reserves the right to amend this Notice of Privacy Practices at anytime in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Midnight Sun Healing** is required by law to comply with this Notice.

Midnight Sun Healing is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: **Jacque Kress** by calling this office at 920.660.3320. If **Jacque Kress** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights or how **Midnight Sun Healing** has handled your health information should be directed to **Jacque Kress** by calling this office at 920.660.3320. If **Jacque Kress** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 01/01/2014.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **Midnight Sun Healing** with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

- I consent to give **Midnight Sun Healing** permission to email my report and images to me and or my doctor or health care provider.

Patient's Name (print)

Date

Patient's Signature

Date

Authorized Parent/Guardian (If under 18 years of age)

Date

Authorized Facility Signature

Date