

ADVANCED HEALTH IMAGING INC

484 Mobil Avenue, Suite 26 ~ Camarillo, CA 93010 ~ (805) 445-1967

Patient Information

Today's Date: _____

Please circle title: Mr. Mrs. Ms. Miss. Dr.			Nickname:	
Last	First	Middle Initial	Date of Birth:	Age
Address			Marital Status	
City	State	Zip	Whom may we thank for referring you?	
Home Phone	Cell Phone		Occupation	
Optional Credit Card on file: # _____ EXP: _____ V-Code _____ Billing Zip Code _____				

**You will receive two full color reports, one for you and one for your Doctor.
Additional reports are available for \$10 each.**

Release Form ~ Authorizations to Use or Disclose Protected Health Information Acknowledgement of Receipt of Privacy Practice

As required by the Privacy Regulations, *Advanced Health Imaging Inc.* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

Biofeedback stress response testing release form:

Bio-energetic evaluation is not a method of diagnosing, nor are the suggested remedies designed to replace any of the medications or treatments currently being provided or recommended by a primary care practitioner.

I fully understand that ALinda L Pressler, ND is not an allopathic doctor (M.D.) and does not pretend to be, but is a bio-energetic practitioner providing services that are not allopathic, but are within the parameters of a natural health and wellness philosophy.

I fully understand that ALinda L Pressler, ND is not diagnosing or treating any illness or disease, but is only measuring the bio-energetic balance and overall stress responses of the body.

I fully understand that ALinda L Pressler, ND is in no way encouraging me to terminate or modify any previous or ongoing therapies under the direction of any licensed practitioner.

I authorize ALinda L Pressler, ND to provide her services to me on my behalf, and hereby release her from any and all claims and potential claims arising out of my actions or failure to act upon her advice.

I hereby authorize this office and any of its employees 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: **Thermal Images and related health history**

For the specific purpose of (describe in detail) **Interpretation of said images**

By way of my signature, I provide **Advanced Health Imaging Inc.** 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 understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control. 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.

I certify that the information given by me is true and correct. I understand that I am financially responsible for all charges at the time services are rendered. Furthermore, I acknowledge that I have received the Notice of Privacy Practices of Advanced Health Imaging Inc.

Patient's Name (print)

Patient's Signature

Date

Name: _____ Birthdate: _____

Address: _____ City _____ Zip _____

Email: _____ Phone: _____ Doctor: _____

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.

Breast Thermography Confidential Questionnaire

- | | Yes | No |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you have any close relative who has had breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed with breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any biopsies or surgeries to your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any breast cosmetic surgery or implants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a mammogram in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a mammogram in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had abnormal results from any breast testing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken a contraceptive pill for more than 1 year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you suffered with cancer of the womb? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had pharmaceutical hormone replacement therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have an annual physical examination by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you perform a monthly breast self exam? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: <input type="checkbox"/> Never: <input type="checkbox"/> Not in last 12 months: <input type="checkbox"/> Not in last 5 years: <input type="checkbox"/> | | |

Have you recently had any of these breast symptoms:	Right Breast.	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

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 discussed in the Report.

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

Signature Today's 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): UO___ UI___ LO___ LI___ Nipple___

Where (right breast): UO___ UI___ LO___ LI___ Nipple___

Treatment: Surgery___ Chemo___ Radiation___ Other___ None___

Diagnosed with other breast disease:

Disease type: Fibrocystic___ Cystic___ Mastitis___ Abscess___ Other___
(please report other types of disease in the history)

Breast biopsies or surgery:

Where (left breast): UO___ UI___ LO___ LI___ Nipple___

Where (right breast): UO___ UI___ LO___ LI___ Nipple___

Areas of the Breast:

UO= Upper-Outer **UI=** Upper-Inner **LO=** Lower-Outer **LI=** Lower-Inner