Breast Thermography Confidential Questionnaire

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.

Please Mark Yes Or No As It Applies To You:	Yes	No
Do you have any close relative who has had breast cancer?		
Have you ever been diagnosed with breast cancer?		
Have you ever been diagnosed with any other breast disease (fibrocystic)?		
Have you had any biopsies or surgeries to your breasts?		
Have you had any breast cosmetic surgery or implants?		
Have you had a mammogram in the past 12 months?		
Have you had a mammogram in the past 5 years?		
Have you had abnormal results from any breast testing?		
Have you ever taken a contraceptive pill for more than a year?		
Have you suffered with cancer of the womb?		
Have you had pharmaceutical hormone replacement therapy?		
Do you have an annual physical examination by a doctor?		
Do you perform a monthly breast self exam?		

How many mammograms have you had in total? _____
What was your age when you had your first mammogram?_____
How many births have you had?_____ Your age at the birth of your first child:_____
Did your period start before the age of 12?_____ Or finish after the age of 50?_____
Do you smoke? Yes____ Never____ Not in the last 12 months____ Not in the last 5 years____
Have you received any COVID vaccines? Yes____ No ____ If yes, how many? _____
Had any type of vaccination in last 4 weeks? Indicate which arm: Left ___ Right ___ No ____

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Have you **recently** had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	**Right Breast**	**Left Breast**
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

PATIENT DISCLOSURE:

I understand that the Report generated from my images is intended for use by trained healthcare 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 _____ Date _____

Authorization to Use or Disclose Protected Health Information

Naturally Unbridled Wellness LLC

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *Naturally Unbridled Wellness 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 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

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

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 or Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

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Naturally Unbridled Wellness LLC
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.

Naturally Unbridled Wellness LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our clients 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 for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with* ***Naturally Unbridled Wellness LLC."***
>
> *"It is our policy to provide a substitute health care provider, authorized by Naturally Unbridled Wellness LLC to provide assessment and/or treatment to our clients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> "*As a courtesy to our clients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to* ***Naturally Unbridled Wellness LLC*** *for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

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

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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.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our clients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*
>
> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of* ***Naturally Unbridled Wellness LLC*** *sponsored fund-raising events."*

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Change of Ownership.
In the event that **Naturally Unbridled Wellness LLC** 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 **Naturally Unbridled Wellness LLC** 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 **Naturally Unbridled Wellness LLC** amend your protected health information. Please be advised, however, that **Naturally Unbridled Wellness LLC** 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 **Naturally Unbridled Wellness LLC.**

- 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
Naturally Unbridled Wellness LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Naturally Unbridled Wellness LLC** is required by law to comply with this Notice.

Naturally Unbridled Wellness LLC 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: **Patti Bartsch, PhD** by calling this office at 608-799-8326. If **Patti Bartsch, PhD** 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 **Naturally Unbridled Wellness LLC** has handled your health information should be directed to **Patti Bartsch, PhD** by calling this office at 608-799-8326 If **Patti Bartsch, PhD** 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:

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

This notice is effective as of _____/_____/_____

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

By way of my signature, I provide **Naturally Unbridled Wellness LLC** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Client's Name (print)

_____ _____
Client's Signature Date

_____ _____
Authorized Facility Signature Date

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