Ingrid Edstrom FNP, M.Ed **PATIENT INFORMATION**

Patient Name:_____Birthdate_____/_____/_____
Last First (MI)

Patient Address:_____Sex: Male_____ Female:_____
Number Street Apt

_____ ____E-Mail:_____
City State Zip *Impo rtant

Home Phone Number_____ Partners____ Married____ Single____
*Preferred
Cell Phone #_____Work #_____*Secure Private Fax # _____

Emergency Contact_____Home Phone_____Work Number_____

Relationship of Patient to Guarantor _____Your Occupation_____

I want my Infrared report provided to me by □ Email or □ Hand mailed. In some circumstance I request and direct IBH/Ingrid Edstrom to email my IR JPEG images; copies of IR Reports or other forms that I want sent to radiologists or other MDs that are involved with my care, Signed: _____ Date:_____

GUARANTOR INFORMATION (Person Financially Responsible)

Guarantor Name_____ Birth date _____/_____/_____

Last First (MI)
Address:_____

INSURANCE INFORMATION (Please Copy a Valid Insurance Card)

Fee For Service/ No Insurance YES
Primary Insurance Name _____ID #_____

Subscriber ame_____Group#_____

Secondary Insurance_____ID #_____

Subscriber Name_____Group # _____

ASSIGNMENT OF BENEFITS:

The Non-Medicare Patient: I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Ingrid Edstrom, FNP, M.Ed.

The Medicare Patient: I request that payment of authorized Medicare/Medigap benefits be made on my behalf to Ingrid Edstrom, FNP, M.Ed for any services furnished me by those providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration, it's agents or my Medigap insurer; any information needed to determine benefits or the benefits payable for related services.

I certify that the information given by me is correct. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I may be financially responsible for any amount billed not covered by insurance, which may include the infrared scan or patient responsibility.

Signature_____ Date_____

HIPPA RELEASE

Ingrid Edstrom, FNP M. Ed. Infrared Breast Health, LLC

Infrared Breast Health, LLC, is a digital infrared imaging clinic, which uses the latest technological advances in thermal imaging to provide non-invasive, physiological evaluations that are adjunctive to other medical diagnostic systems. By providing safe, non-invasive, effective and repeatable studies with thermographic imagery, we offer a cost-effective alternative screening to other more invasive diagnostic tests. Specifically applicable (but not limited to) the evaluation of breast health and muscular-skeletal disorders, thermographic imaging provides baseline information concerning the presence or absence of pathology present in tissue, vessels, and nerves. Additionally thermal imagery is ideal for on-going evaluation of therapeutic intervention and its efficacy. Infrared Thermal Imaging submits all studies to qualified licensed practitioners for interpretation. These practitioners are certified in the practice and interpretation of thermal imaging by the American Academy of Thermology, and International Academy of Clinical Thermology.

It is important to note that thermal imaging is not a stand-alone diagnostic procedure. A licensed practitioner must combine thermographic studies with clinical history and additional information to reach a diagnostic impression. Thermal studies are non-invasive, non-contact adjunctive tests and provide invaluable screening data that can contribute to the diagnostic process. Our studies do, however, provide evidence of the presence or absence of an asymmetry that can be indicative of vascular, neurological, muscular-skeletal or other physiological disorders.

I have read the above information and understand that I am not receiving a diagnosis of any condition. I understand that my thermographic scan is non-invasive and that the scanning camera is 'reading' the heat patterns displayed on my skin. From these patterns a physician qualified in interpretation will indicate any thermal asymmetry. I must take my thermal scan to a health practitioner of my choice, who can combine this information with my clinical history to formulate a diagnosis.

I have reviewed the HIPPA notification from this clinic and understand my patient rights concerning confidentiality.

I want my Infrared report provided to me by ☐ Email or ☐ Hand mailed. In some circumstance I request and direct IBH/Ingrid Edstrom to email my IR JPEG images; copies of IR Reports or other forms that I want sent to radiologists or other MDs that are involved with my care,
Signed:_____ Date:_____

Legal Name (Print and Sign)_____

Date

I authorize Ingrid Edstrom, FNP to use my Infrared images, without revealing my patient information/ identity, as a clinical example or for use in teaching either electronically or in print. I release my images with no copyright enforcement.

Your signature below will acknowledge that you are willing to participate in scientific research projects with strict provisions that will protect your identity.

I would like to be a study participant YES NO

_____

Signature **Date**

Thermography Technician_____ Date of Scan_____

Infrared Breast Health,LLC, Ingrid L. Edstrom,FNP,M.Ed. ID#_____

315 Goodpasture Island Road Eugene OR 97401 Phone 541-302-2977 PST// Fax 541-302-6565 //www.InfraredBreastHealth.com

Patient's Name:_____ **Date:**_____

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

Phone #:_____ **Date of Birth:** _____ **Age:**_____ **Sex:**_____

Have you ever been diagnosed with breast cancer? ❒ Y ❒ N Date: _____ ❒ R ❒ L Breast

Do you have a family history of breast cancer? If yes, who? _____

Date of your last mammogram: _____

Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Date of your last breast ultrasound: _____ Were both breasts imaged? ❒ Y ❒ N

Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Was a follow up biopsy recommended after your <u>last</u> mammogram, ultrasound, or MRI? ❒ Y ❒ N

Date of last physical breast exam by a doctor: _____ ❒ NML ❒ Lump ❒ Thickening – ❒ R ❒ L

What follow up tests did your doctor recommend after this last exam? _____

Date of any breast biopsies: _____ ❒ R ❒ L Breast

What was found on the biopsy? ❒ Cancer ❒ Other _____ ❒ R ❒ L Breast

Any breast surgeries? Date and what was done? _____ ❒ R ❒ L Breast

Have you had a mastectomy? ❒ Complete ❒ Partial Date: _____ ❒ R ❒ L Breast

Was the nipple removed? ❒ Y ❒ N Was the surface skin of the original breast entirely removed? ❒ Y ❒ N

Any breast reconstruction? What was done? (ex. trans flap, implant) _____ ❒ R ❒ L Breast

Any breast radiation treatment? Date of last treatment _____ ❒ R ❒ L Breast

Are you currently pregnant? ❒ Y ❒ N Are you currently nursing? ❒ Y ❒ N

Are you experiencing any of the following with your breasts: ❒ None

❒ Lump ❒ Thickening (date found _____; found by ❒ Self breast exam ❒ Doctor exam)

Pain: ❒ Dull ❒ Sharp ❒ Burning ❒ Stinging ❒ Tenderness ❒ The pain changes with my cycle

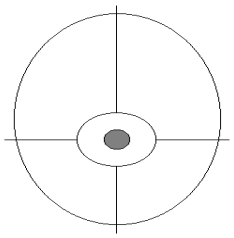
❒ Thickening ❒ Skin changes (❒ Color ❒ Texture ❒ Over the lump)

❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear ❒ Through 1 duct ❒ Through multiple ducts)

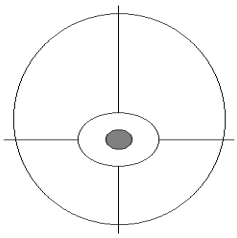
❒ R ❒ L Nipple retraction (❒ For many years ❒ Recently) ❒ R ❒ L Nipple changes (❒ Color ❒ Texture)

❒ Other _____

<u>*DO NOT WRITE BELOW THIS LINE*</u> <u>[M = mammo abn] [W = watched] [X = pain] [# = thickening]</u>



RIGHT



LEFT

High T:_____ Low T:_____ ❒ **Initial Exam** ❒ **Re-Exam** Tech: _____

Pt T = _____ F Rm T = _____ C ❒ R ❒ L Nipple retraction ❒ R ❒ L Areola traction SLQ SMQ ILQ IMQ

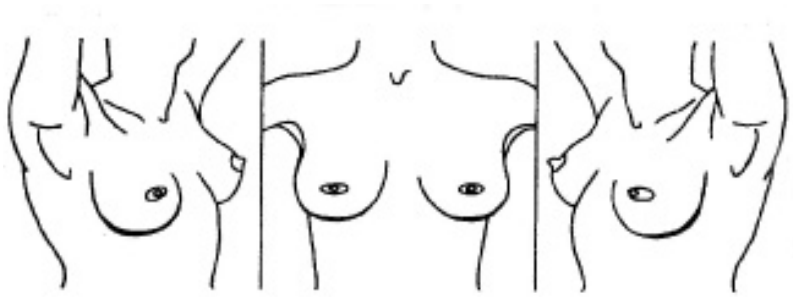
❒ R ❒ L Skin surface bulge or dimple SLQ SMQ ILQ IMQ ❒ R ❒ L Skin changes SLQ SMQ ILQ IMQ

❒ R ❒ L Nipple changes (❒ Color ❒ Texture) ❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear – S M)

Patient Name **ID Number** **Date**

Do you have any of these breast symptoms? No Yes If Yes, please draw on this diagram.
Please draw a line from the listed symptoms to the specific site.

Right Breast
Skin Discoloration
Skin Thickening
Lumps
Pain
Tenderness
Nipple discharge
Changes in Shape
Changes in Size



Left Breast
Skin Discoloration
Skin Thickening
Lumps
Pain
Tenderness
Nipple discharge
Changes in Shape
Changes in Size

Have you had any toxic exposure to aerial spraying from timber, roadside spraying, herbicides, pesticides, horsefly spray, inhaled, mercury, etc. _____
Have you ever had any radiation or x-ray treatments to your chest or back? Yes No, If yes date and why?
_____
Have you had five or more chest x-rays due to scoliosis, asthma, car accidents, etc. _____
_____ How many? _____
How many children do you have? _____At what age was your first term pregnancy?_____
How many of your children did you nurse over 1 month? _____Current cycle day (number of days since first day of period)_____Any fertility Drugs? Yes No,_____
If you've used birth control pills, at what age did you start?____How many years have you taken them?_____
Are you currently taking them? Yes No. If you have passed menopause, at what age did it begin?_____
If you are taking hormone replacement, at what age did you start? _____ How many years taken? _____
Are you currently taking hormones? Yes No. Name:_____ ____Estrogen____Progesterone
Are you currently using any other medications? If yes, what? (i.e. Tamoxifen/Thyroid) _____
Are you currently using a progesterone cream? Yes No (applied to:___Breasts only/___Rotating body areas)
Do you feel that you are overweight? If yes, how many pounds overweight? _____
Have you had your ovaries removed? If yes, at what age? _____
Age at first mammogram?_____ About how many have you had in total?_____
Have you had a total/partial hysterectomy Yes No. Why?(Bleeding, Endometrioses, etc.)_____
Have you been diagnosed with ovarian cancer? Yes No. If yes, date of diagnoses_____
The stage of cancer_____ and date last treatment_____
Have you used over the counter progesterone, or menopausal herbs what type and/or brand?
_____
Do you take any other Pharmaceuticals Medication or Multivitamins/supplements?
_____
_____

"Thermology is a passive (***no*** radiation exposure and ***no*** physical contact) procedure that involves the objective analysis of the body's heat images. The thermology image data will be analyzed by specially trained medical professionals using a scientific method in order to obtain diagnostic indications that will be contained in a specific report. The Thermology report is not itself a diagnosis (medical conclusion) but will contain medical information that may be important in the process of obtaining a diagnosis. The process of obtaining a diagnosis must involve the professional services of your personal physician(s) ***and*** other form of diagnostic evaluations. A normal thermology report does not eliminate all possibility of breast disease. An abnormal thermology report does not itself conclude the presence of breast disease. The diagnostic power of thermology is additive with mammography, MRI, ultrasound and clinical examination. We encourage you to obtain the substantial benefits of combining the appropriate tests for breast disease with the guidance of your personal physician(s). Currently thermology is not common practice in the United States and not all physicians in the US agree on the value of thermology. However, thermology has routinely demonstrated real value among various medical specialists. With this release, you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information. Your signature below will acknowledge that you have read and understand this information, consent to the thermology procedure, data analysis and authorize us to release your thermology report to the physician(s) or others you have specified on this form."

Signature_____ **Date**_____

ADVANCE BENEFICIARY NOTICE (ABN)

Patient's Name:_____

Infrared Breast Health LLC expects that your insurance company which is_____ may not pay for the breast scan. We do expect your insurance to reimburse for the following office visit portions minus your co pay or deductibles.

There are two codes billed on the first visit, the office visit **AND** the scan / procedure code. (As an example: you see your doctor for an office visit and he sends you down the hall for an EKG which is also billed as a procedure done that day).

Breast Scan (**Estimated Cost: $160 in Eugene**) in case you have to pay for them yourself or through other insurance. That code is 93740.

New patient consultation *is billed at $250.00 (Billing code 99204, for a one hour visit) the day of the scan.*

An ***Extended office visit*** *is billed at $175.00* for patients that are out of town and unable to do a follow up visit in the office two weeks later so they stay an additional one to one and a quarter hours after the scan to do the Proactive Breast Wellness Program. The Extended office visit will be in addition to the new patient consultation at your first time of service and the day of the scan *(Billing code 99354).*

Follow up office visits *for local patients, cost $165.00 (Billing code 99214) to do a one hour visit to go over the Proactive Breast Wellness Program when the infrared report is back. Other issues like labs, prescriptions, referrals to other offices etc .are managed during this visit..*

As a courtesy, the maximum you will have to pay for **each** office visit if applied toward deductible will be a reduced rate of $85.00 per office visit.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Ingrid Edstrom is participating with certain insurance companies. However the breast scans may be disallowed, not considered reasonable and necessary by your insurance company, experimental or contract exclusion.

YES. I want to receive these items or services. I understand that my insurance company may not decide to pay for the above services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance does pay for the breast scan, you will refund to me any payments I made to you that are due to me. I am still responsible for the co pay or deductible for the office visits as discussed above. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

Signature of patient:_____ Date:_____

Physicians signature:_____ Date:_____

Consent to Infrared Imaging / Thermography

Infrared Breast Health, LLC.
315 Goodpasture Island Road Eugene, OR 97401
Tel: 541-302-2977 Fax: 541-302-6565

Instructions: Please read the following carefully and initial your name on the line at the end of each section.

I understand that thermography is a procedure utilizing infrared imaging cameras to visualize and obtain an image of the infrared heat coming off the surface of the skin. The thermographic procedure is performed in order to analyze temperature patterns on the body that may or may not indicate the presence of an abnormal process. Consequently, a normal thermogram does not rule out the presence of significant pathology. All thermography reports are meant to identify heat patterns that suggest potential risk markers only and do not in any way suggest diagnosis and/or treatment. Your thermogram report is meant to be used by your treating doctor as an adjunctive aid in the assessment of your health. The report is not to be used for self diagnosis and/or treatment. _____

I understand that infrared imaging of the breast is not intended as a replacement for or alternative to mammography, ultrasound, MRI or any other form of imaging. Thermography is not a stand-alone screening tool, meaning that it is not to be used by itself for screening. __

I understand that infrared imaging of the breasts and mammography do not provide the same information on breast tissues; and therefore, provide different values on breast tissue assessment (thermography looking for physiological changes and mammography looking for anatomical changes). _____

I understand that the doctor and/or technician providing the infrared imaging, and the doctor interpreting the images, are not diagnosing and/or treating breast abnormalities. Follow up care relating to treatment must be done by properly trained and licensed health care specialists. _____

I understand that if, by any chance, a questionable thermal finding is discovered on my thermogram, I will comply with any and all follow-up or referral recommendations made on my report; such as following up with an ultrasound / mammogram / MRI / etc. or with my primary care doctor to ensure I receive proper care. _____

I understand that I will be disrobed from the waist up for breast exams and buttocks exposed for lower body exams. I will then be imaged with an infrared camera. I understand that this procedure does not use radiation, is not harmful to me, the equipment does not touch my body, and that its sole function is to produce an image of the heat coming off my body. _____

I understand that thermography reports do not in any way suggest diagnosis and/or treatment. No surgical procedure should be based on thermal imaging alone. Additional procedures, which depend on the nature of the condition and/or body region, are needed to achieve a final diagnosis. _____

I understand that thermography must not be confused with EBT, CT, or MRI full body imaging. These are structural imaging technologies that look for the physical presence of tumors and other structure changes inside the body. Thermography does not provide this type of imaging; and as such, cannot be used to screen for the spread of cancer (metastasis). _____

I understand that the results of my thermograms may be made available to my doctors and others as I so designate for further analysis in the overall evaluation of my health. I have also been given pre-imaging instructions to follow and I acknowledge that I have complied with the preparation protocol prior to the procedure. _____

I understand that the information I have reported on the intake forms, and the resultant report and/or images, will be sent via facsimile and/or electronic mail to personnel involved in the process, and/or my health care provider(s). As such, my private health information has the possibility of being seen by unauthorized personnel. Having understood this I give my full consent to having my private health information sent via facsimile and/or email. A new encryption software is soon to be added to all clinics to address this issue_____

Having understood the above, and having received satisfactory answers to any and all questions that I may have had concerning the purpose and outcome, risk factors and benefits of thermography, I hereby consent to both initial and all subsequent infrared imaging.

Patient's (Guardian's) Name:_____

Patient's (Guardian's) Signature:_____ Date:_____

Witness:_____ Date:_____