

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 *Important

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 Name _____ 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

Thermography Technician _____

Date

Date of Scan _____

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 last 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

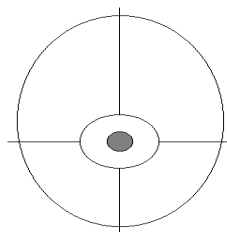
Thickening Skin changes (Color Texture Over the lump)

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

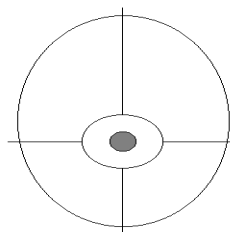
R L Nipple retraction (For many years Recently) R L Nipple changes (Color Texture)

Other _____

DO NOT WRITE BELOW THIS LINE [M = mammo abn] [W = watched] [X = pain] [# = thickening]



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

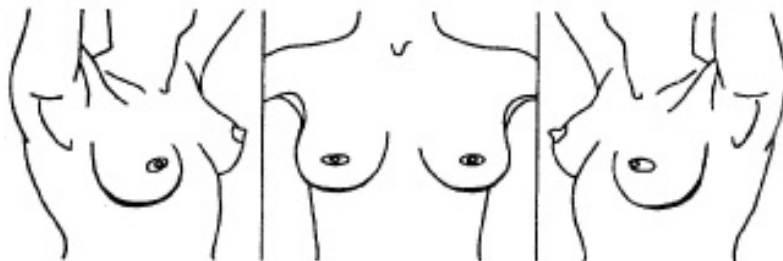
ID Number

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: \$150 in Eugene/Roseburg or \$190 when in done in Portland (circle site) _____), 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.
1102 Hodson Lane, Eugene, OR 97404
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: _____

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

1102 Hodson Lane Eugene, OR 97404 Phone 541-302-2977 PST//Fax 541-302-6565//www.InfraredBreastHealth.com

Pre-Examination Instructions

Patient preparation: If you have a temperature from an infection call and please reschedule.

The following instructions must be strictly adhered to before you arrive for your appointment:

No prolonged sun exposure/tanning beds (sunburn) to the breasts 5 days prior to your exam. Wear a jewel neckline and short sleeves but no plunging tank tops. Sunscreen will not help.

No exercise 4 hours prior to your exam ie biking and NO HEAVY upper body lifting 4 days prior. You can go to the gym but do lower body or a treadmill exercise. Pulling muscles in the anterior chest will alter the scan results. Also avoid leaf raking and lifting of heavy suit cases 4 days prior.

Do not participate in massage/chiropractic, acupuncture, TENS, physical therapy or electrical muscle stimulation for 48 hours prior to exam.

No physical stimulation or treatment of the breasts, chest, neck, or back for 24 hours before the exam.

No use of lotions, creams, powders, or makeup on the breasts the day of the exam.

No shaving or other hair removal of the areas to be imaged 24 hours prior to exam.

No use of deodorants or antiperspirants the day of your exam.

Do not smoke two hours before the test.

If bathing, it must be no closer than 1 hour before the exam. No hot tubs for 24 hours before the exam.

If you are nursing, please try to nurse as far from 1 1/2 to 2 hours before the exam as possible.

If you are using pain medications, please avoid taking them for 4 hours prior to the examination. You must consult with the prescribing physician for his or her consent prior to any change in medication use such as this.

Please note: During the examination you will be disrobed from the waist up for both imaging and to allow for the surface temperature of the body to equilibrate with the room. A female technician will perform the imaging for you.

Surgical procedures such as implants, reductions, and biopsies do not interfere with infrared imaging. Breast thermography is perfectly safe to have during pregnancy or when nursing. The procedure may also be preformed during any part of the menstrual cycle without effecting the interpretation of the images..