

MAXILLO-FACIAL INTAKE FORM

Infrared Breast Health, LLC

102 Hodson Lane Eugene, OR 97404 (541) 302-2977 (541) 302-6565

CLIENT NUMBER _____

DATE _____

Patient's Name _____

Address _____ LAST FIRST

Address _____

NUMBER STREET CITY STATE ZIP CODE

Home Phone _____ Work Phone _____ E-mail _____

Date of Birth: _____ Age: _____ Sex: M F Weight: _____ Height: _____

Name of Physician (if referred by) _____

Fax or Address (if results are requested) _____

HEALTH EVALUATION

1. If a physician has EVER told you that you had one of the following disorders, please CIRCLE it and write the approximate date of the diagnosis to the listed disorder:

ANGINA BLOOD CLOTTING PROBLEMS CANCER DIABETES HIGH BLOOD PRESSURE HEART ATTACK

HIGH BLOOD CHOLESTEROL INTERMITENT CLAUDICATION PHLEBITIS THYROID DISORDER NEUROPATHY

MIGRANE OR CLUSTER HEADACHES RAYNAUD'S DISEASE STROKE (CVA) TIA (MINI STROKE) VARICOSITIES

2. Do you currently have any of these problems? Circle medical concerns if Yes.

Facial Pain Dental Pain Pain with Chewing Jaw Locking/Clicking/Popping TMJ Pain

Headaches Ear Pain Ear Noise Sinusitis Poor Hearing Problem with Vision

3. Have you EVER used tobacco in any form? YES / NO If yes, please give the approximate number of years you used tobacco _____, the approximate amount _____ packs / day you used and the _____ years since you quit.

4. Has a first-degree relative (Father, Mother, Sister, or Brother) had a heart attack or stroke before age sixty?

YES / NO If yes, who (details)? _____

_____ How old were they _____ and are they living now? YES / NO

5. Have you EVER had ANY surgery to your HEAD NECK CHEST ARMS LEGS? YES / NO If yes, please provide the date and description of the surgery. _____

6. Please list ALL PRESCRIPTION DRUGS that you have taken in the past three (3) months.

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: _____

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: _____