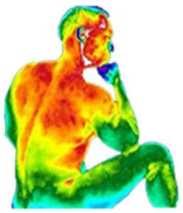


Northeast Thermography
Medical Imaging Center
Cutting Edge Technology for Early Disease Detection

New Client Intake Form

Name_____ Patient ID: _____
DOB_____ Age _____ Study Type:
Street _____ WFB / MFB / WUB / MUB / BRST / ROI
City_____
State _____ Zip _____ Method of Payment:
Occupation _____ Check: #_____
E-mail_____ Credit: VISA MC Discover AmEx

Phone (include area code)
(H) _____
(W) _____
(C) _____ Text OK? Yes / No

Email Report to You: Yes / No

Reason for today's visit:

_____

_____

_____

Current Symptoms:

_____

_____

_____

Current Treatment:

_____

_____

_____

2 Chelsea Place, Clifton Park, NY 12065
518-983-6564
www.medthermography.com

Previous illnesses:

_____

_____

_____

Previous Surgeries/Dates:

_____

_____

_____

Injuries/Dates:

_____

_____

_____

Do you want your report sent to your Health Care Provider(s)? (circle one) Yes / No

Provider's name and address: (1st is No Charge. Each additional is $5)

_____

_____

_____

This information is confidential. All information is correct to my knowledge.

Signed:

_____Date:_____

How Your Images, Documents and History May Be Used

Northeast Thermography Medical Imaging Center (an affiliate of Medical Thermography Associates), as a member of the International Association of Medical Thermographers (IAMT) is currently compiling a database of case studies for use in future statistical analysis, case studies for teaching purposes, correlational studies and an image base for publicity and public education with known, accurate case histories. We are also compiling images for advertising/marketing purposes.

If your thermography images and/or study (or studies) are used for any of the reasons specified above, we certify that:

- Any images used for marketing purposes shall have all references to you, the client/patient removed and there will be no personally identifiable information in the image.
- Your identity (including information that could be suspected of leading to your identity) remains completely confidential, with only the case reviewers of the IAMT even knowing your name
- Copyright to any material (images, history) shall be jointly owned by you, the Client/Patient and Northeast Thermography Medical Imaging Center. Copyright will not be granted or inferred onto other entities without your express written permission.
- No other organization will approach you directly for further information or solicit you for any further studies. Any copies of test results etc. that are provided to us as part of your case study will have all personally identifiable information or reference to you removed before being used further.
- The information supplied shall not be used to cause harm or defame from any other person (as defined by law) or profession.
- Should these stipulations be breached, this consent permission form is to be immediately revoked and all materials relevant to your case study will be returned and/or destroyed.
- Should you be asked to be a part of an ongoing study by us, all further imaging that forms a part of that study will of course be without charge as a thank you for your co-operation.

I, _____ do hereby give permission to Northeast Thermography Medical Imaging Center to use my thermography images, thermal studies, case history, and any supporting documentation for case reviews, including a peer/physician review.

_____

Signature **Date:**

Name (Print) _____

Breast Thermography Client Disclosure

Breast thermography is a non-contact and non-invasive procedure. The value of thermography as a breast imaging modality is its ability to measure skin temperature changes. It offers women information that no other procedure can provide regarding breast health.

Breast thermography is a discovery tool for breast health, not a screening test for breast cancer. This is to clarify that thermography is not a replacement for or alternative to mammography or any other form of breast imaging. Breast thermography is best used as discovery assessment for breast health only.

Thermography captures and records temperature variations on the skin, which provides vital information directly influenced by complex metabolic and vascular activity. This information does not in any way suggest diagnosis and/or treatment. Thermography can be beneficial as an assessment of breast health in combination with breast self-examinations and physical breast exams by a doctor. Other, more invasive tests, such as mammography, ultrasound and MRI may be ordered by a licensed physician for screening of disease in the breast.

A reported "Elevated index of Concern" impression by the interpreter indicates that there are enough thermal irregularities that justify more investigation related to breast health. It does not suggest that it is suspicious for any specific disease, including cancer. However, such an impression will be accompanied by an intentional recommendation for further clinical evaluation.

If you detect a lump or any other change in your breast before your next screening thermogram, consult your doctor immediately.

Notice to patients presenting with previously diagnosed cancer: Thermography interpretation in your report does not include information or recommendations related to the measured changes in disease beyond skin temperature changes and patterns. We recommend continued monitoring with available additional testing as you personally prefer or recommended by a physician.

By Signing below, I certify that I have read and understand the statement above and consent to the breast health discovery examination and acknowledge this is not a cancer screening.

Client Signature _____ Today's Date_____

2 Chelsea Place, Clifton Park, NY 12065
518-983-6564
www.medthermography.com

Extended Breast Questionnaire

Client Name: _____ Date: _____

Diagnosed Breast Disease/Conditions:

Fibrocystic _____ Cystic _____ Mastitis _____ Other _____

Dense Breast Tissue? (Y/N) _____

If Diagnosed with Breast Cancer:

Cancer Type: Metastatic ____ Local ____ Lymph Node Involvement: ___

When Diagnosed: Month _____ Year _____

Where (L Breast): UO ___ UI ___ LO ___ LI ___ Nipple ___

Where (L Breast): UO ___ UI ___ LO ___ LI ___ Nipple ___

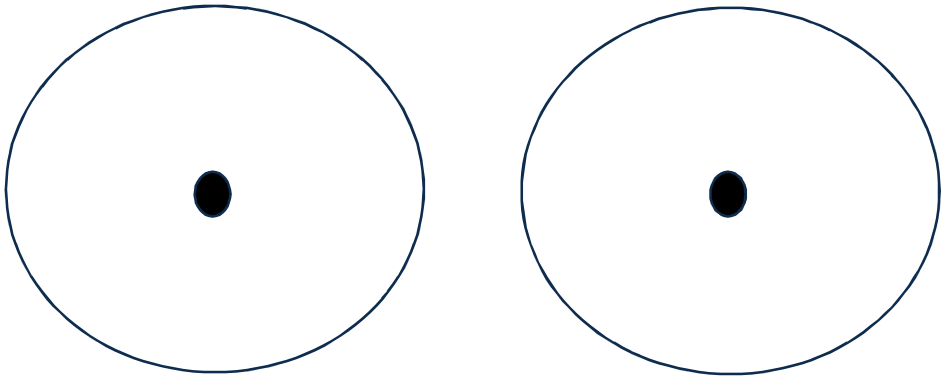
Treatment: Surgery ____ Chemo _____ Radiation _____

Integrative ____Natural ____ None _____

Biopsies of the Breast? (Y/N) _____

Where (L Breast): UO ___ UI ___ LO ___ LI ___ Nipple ___

Where (L Breast): UO ___ UI ___ LO ___ LI ___ Nipple ___



Right **Left**

Definitions: UO = Upper Outer Region UI = Upper Inner Region

LO = Lower Outer Region LI = Lower Inner Region

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information (PHI) to the following person(s), entity(s), or business associates of this office:

Physicians Insight, LLC

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation and Analysis of said Images**

This Authorization also allows for the transfer of the report of my thermal study by Physicians Insight's to be sent to me by the use of electronic medium (E-Mail). _____ (initial)

Effective dates for this authorization:

____/____/____ (today's date) THROUGH ____/____/____ (5 years from today)

This authorization will expire at the end of the above period.

I understand that if I authorize the information disclosed above to additional parties, the disclosed information may no longer be protected for reasons beyond your control.

Over →

I understand that I have the right to:

- 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.
- Inspect a copy of Patient Health Information being used or disclosed under federal law.
- Refuse to sign this authorization.
- Receive a copy of this authorization.
- 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 affect eligibility for benefits whether I provide authorization to use or disclose protected health information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date:

_____ _____

Authorized Signature of Northeast Thermography Medical Imaging Center Date:

Health Care Provider Information Form

Client Name: _____ **Date:** _____

Street Address _____

City: _____ **State:** _____**Zip Code:** _____

NOTE: We provide one (1) report at no charge to your provider of choice. Please indicate which provider you want us to send report(s) to. Additional reports are $5 each.

My Primary Medical Provider: _____

Open to Thermography? Y / N

Address: _____

Phone No: _____

Email: _____

Hospital/Practice Affiliation: _____
(CDPHP, Saratoga Hospital, SPHP, etc)

My Ob-Gyn (or Secondary Provider): _____

Open to Thermography? Y / N

Address: _____

Phone No: _____

Email: _____

Hospital/Practice Affiliation: _____
(CDPHP, Saratoga Hospital, SPHP, etc)