Holistic Breast Specialist & Naturopathic Doctor™
DEIKA KING

14526 Old Katy Rd. Ste. 108 Houston, TX 77079 832-422-7271

3 Month/Annual

3 Month/Annual Form

Name: _____ D.O.B. _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____(Home) _____(Cell)

E-mail: _____ Occupation: _____

How did you find out about us? _____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

BRAS Thermography uses a Meditherm Digital Infrared Thermal Imaging camera to provide a 15-minute non-invasive test of physiology. DITI detects the minute physiologic changes that accompany breast pathology.

I understand that BRAS Thermography does not provide a medical diagnosis, but simply acts as the clinical Thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to BRAS. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider. A doctor to doctor consultation can be arranged between Meditherm and your doctor if necessary.

I give my permission for the Clinical Thermographer at BRAS to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that my thermography report will be emailed to me so that I can share with my health care practitioner or primary care doctor.

Referring Physician's Name: _____

Client Signature_____ Date_____

Thermographer's Signature_____ Date_____

All Clinical Thermographers are trained and certified by the ACCT.

Current Complaint: _____ **DOB:** _____

Updates since last Thermogram:

Breast Changes/Breast Test or procedures

Surgeries

Medication Changes

Other Treatments

Have you recently had any of these breast symptoms?	*Right Breast*	*Left Breast*
Pain		
Does pain subside after menstrual cycle ends		
Tenderness		
Does tenderness subside after menstrual cycle ends		
Lumps		
Change in breast size		
Does change in breast size subside after menstrual cycle ends		
Areas of skin thickening or dimpling		
Secretions of the nipple		

PATIENT DISCLOSURE

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.

I understand that the Report generated from my images is intended for use by trained health care 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.

Patient Signature _____ Today's date _____

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, ***Deika King, Naturopath,*** **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 this 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 in the use 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's 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 understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*