14521 Old Katy Rd. Ste. 240 * Houston, TX 77079 * Tel. 832-422-7271 * Fax 832-747-6146
www.DeikaKingND.com

NEW THERMOGRAPHY CLIENT INFORMATION

Thank you for choosing us your Thermography screening. Our goal is to work with you in getting to the "root cause" of your problem. We do our best to make your experience a rewarding one and your feedback is welcomed.

Please take some time to go over these forms and sign where appropriate. Once completed you have the option of emailing them, faxing them, or dropping them off at our office. **All documents must be *completed prior to arriving* for your thermography appointment, otherwise it will cut into your scheduled visit and we may have to either shorten it or cancel you visit for the day.**

If you choose to email or fax, please call our office to confirm the receipt of your documents.

If any additional information is necessary, you will be called prior to your scheduled appointment.

Tel. Number: 832-422-7271
Fax Number: 832-747-6146
Email Address: assistant@deikakingnd.com

Love & Health,

Deika King, ND, MS, MH, CCT
Naturopath, Nutritionist, Herbalist, Clinical Thermographer
Holistic Breast Specialist & Naturopathic Doctor

Welcome

The Owner:

Deika King is a Holistic Practitioner Servicing Houston/Katy and surrounding areas. She is a Doctor of Naturopathy, Nutritionist, Master Herbalist, Clinical Thermographer, Holistic Cancer Coach, Health Coach, Integrative Cancer Educator, and Registered Natural Health Practitioner. She specializes in women's breast health and addresses chronic and acute concerns with the use of nutritional therapy.

At your Functional Breast and Body Screening:

You will be required to fill out an assessment specific to the type of appointment you scheduled. You will be required to allow a minimum of 60 minutes for your first appointment and at least 30 minutes for your follow up future screenings. Appointments may run longer based on your need and available time. Please make sure that you arrive promptly to your appointment. We request that if you are running late that you call the office and inform us. ***We require that your assessment be completed by the time you arrive to our office for a thermography screening. Please review our cancellation policy prior to confirming your first appointment.***

Office Fees: Our office fees are based on the services and time you require with your practitioner. Please call our office or visit our website for specific office fees for services offered.

Payment: We are a cash-based practice. This means that we do not accept insurance, but we do accept cash, credit, debit, checks and Health Savings Accounts. **It is your responsibility to check with your HAS for Flex plan to make sure that they will cover our services before the service has been provided to you. We are not responsible if they do not. Please do your due diligence.**

- **All initial appointments require a 30% reservation fee. This fee will be applied to services rendered on the day of your appointment and must be paid at the time the appointment is scheduled.**
- **Appointments cancelled within 48 hours will be refunded their reservation fee.**
- **No show or late cancellations will be charged 50% of the cost of the Thermography appointment.**

Note: If for any reason, we are not able to obtain payment for the missed appointment, or late cancellation with credit card on file; you will not be able to schedule another appointment until all previous payments are paid in full.

****** To provide better service to our clients, we do not overbook to compensate for no shows; your appointment time is dedicated only to you, therefore, we must bill for missed appointment. We pride ourselves in not having our clients wait 30 minutes before being seen and then spending only 5 minutes as one would experience in a Medical Doctors office. Please be considerate of our time and prep time to see you******

Initial _____2

CLIENT PRE-SCREENING INFORMATION

Please comply in order to receive the most accurate reading for your scans.

3 Months Prior

No major surgery in area being imaged
No radiation therapy
Women: cease pregnancy, lactation and breastfeeding

1 Month Prior

No minor surgery to area being imaged, i.e. biopsy

1 Week Prior

Avoid strong sunlight or tanning sessions (especially sunburn). Avoid vaccinations (must wait 1 week after for scan)

24 Hours Prior

No treatment: chiropractic, mammogram/x-ray, acupuncture, massage, dialysis, physical therapy, electrical muscle stimulation, steam room, sauna, hot or cold pack use.

Day of the Exam

No lotions, powders, or oils on the areas being imaged
No make-up on face or neck
No deodorant or antiperspirant
No shaving of areas to be imaged

2 Hour Prior

No smoking
No exercise
No stimulants - caffeine, tea, chocolate, alcohol

1 Hour Prior

No bathing
No hot or cold food or beverages (room temp is fine)

What to Wear

Loose fitting
clothes No jewelry
Hair should be pinned up (we have hair accessories to keep your hair up, if you forget)
No underwire bra

What to Bring

Intake form and other documents requested for your screening. You may bring in other screening results (mammogram, ultrasound, biopsy, etc.) that relates to your screening.

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ABOUT THE VISIT – OUR PROCESS

When you arrive to your office, we will review your intake forms and any document related to your screening. We may ask you to clarify information on your intake form and we will discuss any concerns you have about either your health or your screening. We will discuss the screening process and get you settled in. You will need to sit long enough to have your body get adjusted to the room temperature before we begin screening. You will be asked to undress based on the type of screening you have scheduled. You will be given directions on positioning for best image results.

Once imaging is completed, we will review the images and discuss them with you. If you are scheduled for a screening that involves the breast, we will provide you with a breast health prevention booklet and we will review the booklet with you. This is designed to educate clients on ways to keep their breast healthy.

WHO TAKES THE IMAGES?

Your screening will be performed by Deika King. Deika King is not a medical doctor. She is Level II Certified Clinical Thermographer. She received her thermography screening education through the American College of Clinical Thermology (ACCT) which is associated with Duke University.

WHO PREPARES THE REPORTS?

Our reports are interpreted by a series of medical doctors trained in the study of thermology. These are licensed medical doctors that are required to have continued their education in thermology over the years. To create your report, our interpreting doctors need to consider the information in your intake form, which is why it is important that we review it prior to screening. The doctors write their interpretation in what we call a Report of Findings, which is helpful for your practitioner in designing a health protocol plan specific to your needs.

RECEIVING YOUR RESULTS

All reports will be received electronically between 2-3 days. You will receive the interpreting doctor's report along with images. If you need your report within 24 hours, we are able to provide urgent reporting for a fee of $50. Once you have received your report, we are more than happy to review those with you simply schedule a 15 min ($50) or 30 min ($90) Thermography Consultation. To schedule a phone report review, you will need to visit our website at www.DeikaKingND.com under book online to schedule your thermography consultation.

SERVICE OPTIONS

- **Breast – Initial and Annual - $225**
- **Breast Baseline (3mths) - $225**
- **Women's Wellness - $370**
- **Full Body Scan - $510**
- **Region of Interest - $200**
- **Immune scan - $260**
- **Breast Baseline Package (initial & 3mth scan) -$685**

  Includes: 1st and 2nd breast scan, breast risk assessment, breast consultation (1hr), Non-invasive assessment, 2- BioMat Detox Sessions, Prevention Education and Booklet, Toxicity Assessment, 10-Day mini eCourse, Scarf, Dry Brush and 1 Supplement.
- **Comprehensive Package (initial, 3mth and annual scan) - $1250**

  Includes, 1st, 2nd, and 3rd (annual) thermography breast scans, breast risk assessment, breast consultation (2hrs), Non-invasive assessment, 4-BioMat Detox Sessions, 3 Ionic Foot Detox Bath, Prevention Education, Toxicity Assessment, 10-Day mini eCourse, Scarf, Dry Brush, and 3 Supplements.

Initial _____

BREAST HEALTH KIT OPTION **(please select if interested)**

*** Breast Care Kit (address breast concerns and lymphatic congestion) -$85**
Breast massage oil, high potency liquid iodine, vitamin D3, lymphatic dry brush, selenium, breast prevention booklet.

If you have cancer and would like something specifically for your situation, please schedule a Holistic Cancer Evaluation to address those particular concerns.

I have read and understand the above information and I accept the policies of B.R.A.S. Thermography & Wellness.

My signature confirms that this information is true.

Signature: _____ **Date:** _____

Deika King, TND, MH, CCT, PSc.D

Holistic Breast Specialist & Naturopathic Doctor

INFORMED CONSENT STATEMENT

I, _____hereby attest and agree to the following:

1) I fully understand that Deika King is a lay natural health advisor who deals strictly in helping people to improve their general health through better nutrition, noninvasive natural remedies, such as vitamins, mineral, herbs, dietary changes, improved lifestyle, health habits, and positive mental attitude.

2) I fully understand that Deika King is not a licensed physician and cannot diagnose disease, prescribe drugs, or recommend treatments for specific disease conditions.

3) I understand that all evaluations/analysis performed by Deika King or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed physicians.

4) I understand that Deika King never claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services, or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.

5) I certify that Deika King or her representatives have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Deika King or her representatives responsible for the consequences of my decisions.

6) I certify that I am here on this and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

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7) I understand that I am responsible and accountable for all charges incurred, and any subsequent interest and/or past due charges for unpaid balances, including any charges for collecting on all “past due” bills. Due to Federal Regulations, opened supplements cannot be returned for a refund.

I have read and understand the foregoing and agree to the terms and conditions set therein.

Date: _____ **Referred by:** _____

Client Signature: _____

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Holistic Breast Specialist™ & Naturopathic Doctor
DEIKA KING

Office Use Only!

Filed: _____

Mailed: _____ Emailed: _____

Payment Type:

Breast Health Check

Name: _____ D.O.B. _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ (Best #) E-mail: _____

How did you hear about us:_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

BRAS (Breast Research Awareness & Support) 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 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 two sets of thermography pictures will be mailed or emailed to me so that I can share one with my health care practitioner or primary care doctor.

PATIENT DISCLOSURE

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.

CLIENT SIGNATURE: _____ DATE: _____

All Clinical Thermographers are trained and certified by the ACCT.

Patient Name: _____ **DOB:** _____

Significant Past Illnesses:

Illness	*Year(s)*	*Comments*

Previous Surgeries Especially Breast and Dental Surgeries:

Type of Surgery	*Year(s)*	*Comments*

Present Health Problems *(please indicate current concerns and/or symptoms)*:

Medical Problem	*Date of Onset*	*Comments/Concerns/Symptoms*

Present Medications:

Medication Name	*Taken For*	*Date Started*

Family Medical History:

	Age if Living	**Age at Death**	**Cause of Death**	**Major Medical Health Problems** (Bubble in all that apply)
Mother				○ Breast Cancer ○ Cancer ○ Stroke ○ Heart Attach/MI ○ Hypertension ○ Other (specify):_____
Father				○ Breast Cancer ○ Cancer ○ Stroke ○ Heart Attach/MI ○ Hypertension ○ Other (specify):_____

Do you participate in regular *(annual/bi-annual)* dental visits? ○ Yes ○ No

General overall health currently: ○ Excellent ○ Good ○ Fair ○Poor
If *fair* or *poor*, please explain: _____
_____

Other Current Treatments: _____
_____

Extended Breast Questionnaire

Have you ever been diagnosed with breast cancer? Yes _____ No_____

Type of Cancer	*Date of Dx*	*Presently Being Treated*
Metastatic	Mo Yr	
Local	Mo Yr	
Lymph node involvement	Mo Yr	

Where on the breast *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO
Right Breast	UO	UI	LI	LO
Treatment	Surgery _____	Chemo _____	Radiation ___	None _____

Diagnosed with breast disease: Yes____ No____ *If yes, please check* ***Type of Disease*** *below:*

Fibrocystic ___	Cystic _____	Mastitis _____	Abscess _____	Other_____

Breast biopsies or surgery *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO	Nipple
Right Breast	UO	UI	LI	LO	Nipple

Date of last mammogram or ultrasound_____

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.

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		

Have you had any cosmetic fillers (i.e.: Botox, Restalyn, etc.) in the past 12 months?:
○ Yes ○ Never ○ Not in last 12 months

Have you ever had a thermographic scan? ○ Yes ○ Never ○ Not in last 12 months
If yes, please tell us when and with whom. There is a possibility we can access your past report for comparison.

_____
_____
_____
_____
_____

Breast Thermography Confidential Questionnaire

Please answer all questions – Please circle as needed	*Yes*	*No*
1. Any close relative ever had breast cancer? Whom?		
2. Have you ever been diagnosed with breast cancer?		
3. Have you ever been diagnosed with any other breast disease? Fibrocystic Mastitis Cystic Abcess		
4. Have you had any biopsies or surgeries to your breasts?		
5. Have you had any cosmetic surgery? Implants Reduction Lift Date:		
6. Do you have dense breast tissue?		
7. Have you had a mammogram in the past 12 months?		
8. Have you had more than 30 mammograms in your lifetime?		
9. Have you had a mammogram or US in the past 5 years? Date:		
10. Have you had abnormal results from any breast testing?		
11. Have you ever taken an oral contraceptive pill in the last 4 years? If yes, are you still taking a contraceptive pill?		
12. Have you ever been diagnosed for ovarian uterine or cervical cancer?		
13. Have you had hormone replacement therapy? Bioidentical Pharmaceutical		
14. Do you have an annual physical examination by a doctor? Does this include a gynecological exam?		
15. Do you perform a monthly breast self-exam?		
16. Did your periods start before the age of 12?		
17. Did your periods finish after the age of 50?		
18. Have you ever given birth to a child?		
19. Have you ever smoked for more than 5 years?		
20. Is your menstrual cycle irregular?		
21. Do you experience cramping during your menstrual cycle?		
22. Do you observe heavy bleeding during your menstrual cycle?		
23. Do you have breast pain and tenderness that comes and goes?		
24. Do you have any breast lumps that come and go?		
25. Do you have low libido?		
26. Do you have hot flashes?		
27. Have you ever been diagnosed with endometriosis?		
28. Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)?		
29. Have you ever been treated for infertility?		
30. Do you have swelling in the neck or trouble swallowing?		
31. Have you even been diagnosed with any thyroid disorders?		
32. Do you regularly experience fatigue?		
33. Have you experienced any recent hair loss?		
34. Had vaccination in last 4 weeks? Left Arm____ Rt. Arm _____		

35. What was your age when you had your first mammogram? _____

36. How many births have you had? _____ **Your** age at the birth of your first child? _____

37. Smoker status? ○ Yes ○ Never ○ Not in last 12 months ○ Not in last 5 years

Which of the following do you have concerns about and/or want more information about (for you or a family member?

__ Brain health __Cellulite __ Cleansing __ Hormone balancing __Immune Boosting

__ Insomnia __ Memory __ Neuropathy __ Quit smoking __ Skincare

__ Exercise __ Mood __ Stress Relief __ Weight Loss __ Thyroid

Do you have any additional Concerns? _____

_____

_____

_____

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, ***BRAS Thermography & Wellness, LLC,*** **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 (today's date) _____/_____/_____ .This authorization will expire in 1 year _____/____/____/.

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*

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.
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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*