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******

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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.

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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

Confidential Questionnaire
Male *Full/Half Body*

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cellular)_____(work)_____

E-Mail Address_____

Referring Physician_____

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.

Head & Neck

	Yes	No
1. Do you suffer with headaches? If yes, ○ once a month or less ○ more than once a month	○	○
2. Do you have allergies?	○	○
3. Do you have TMJ or does your jaw click?	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder?	○	○
6. Do you have neck pain?	○	○
7. Do you have upper back pain?	○	○
8. Do you have a history of carotid artery disease?	○	○
9. Do you have a family history of stroke?	○	○
10. Do you currently suffer with sinus problems?	○	○

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	○	○
Lung disease?	○	○
Mid to upper spine disorders?	○	○

Revised 2/07/08

	Yes	No
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
Have you ever had surgery to your:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
4. Do you have asthma or shortness of breath?	○	○
5. Do you currently smoke?	○	○
6. Have you smoked in the past 5 years?	○	○

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

	Yes	No
1. Do you suffer with acid reflux?	○	○
2. Do you have pain in the:		
Stomach?	○	○
Below the right breast?	○	○
Below the left breast?	○	○
Abdomen?	○	○
Lower back?	○	○

3. Have you had surgery or disease in the:	Yes	No
Stomach?	○	○
Spleen? Left upper quadrant	○	○
Liver? Right upper quadrant	○	○
Kidneys?	○	○
Intestines?	○	○
Abdomen?	○	○
Lower back?	○	○

Do you have any special concerns or are there any details related to the information above?

Legs & Feet

(Check only if "yes")

1. Do you suffer with pain in the:	LT	RT
Leg?	○	○
Sciatica?	○	○
Buttocks/Hip?	○	○
Knees?	○	○
Ankles?	○	○
Feet?	○	○

2. Have you had surgeries to:	LT	RT
Leg?	○	○
Sciatica?	○	○
Buttocks/Hip?	○	○
Knees?	○	○
Ankles?	○	○
Feet?	○	○

Do you have any special concerns or are there any details related to the information above?

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgeries to:	**LT**	**RT**
Shoulder?	○	○	Shoulder?	○	○
Elbow?	○	○	Elbow?	○	○
Arm?	○	○	Arm?	○	○
Hands?	○	○	Hands?	○	○

	Yes	No
3. Have you ever been diagnosed with diabetes?	○	○

Do you have any special concerns or are there any details related to the information above?

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement 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*