PATIENT INFORMATION

Please list, in order of importance, your chief concerns:

1. _____ 3. _____

2. _____ 4. _____

Have you ever been diagnosed with breast cancer? ❒ Y ❒ N Date: _____ ❒ R ❒ L Breast

Do you have a family history of breast cancer? If yes, who? _____

Date of your last mammogram: _____

Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Date of your last breast ultrasound: _____ Were both breasts imaged? ❒ Y ❒ N

Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Was a follow up biopsy recommended after your LAST mammogram, ultrasound, or MRI? ❒ Y ❒ N

Date of last breast exam by a doctor: _____ ❒ Normal ❒ Lump ❒ Thickening – ❒ R ❒ L

Any tests recommend after this last breast exam? (ex. mammogram) _____

Date of any breast biopsies: _____ ❒ R ❒ L Breast

What was found on the biopsy? ❒ Cancer ❒ Other _____ ❒ R ❒ L Breast

Any breast surgeries? Date and what was done? _____ ❒ R ❒ L Breast

Have you had a mastectomy? ❒ Complete ❒ Partial Date: _____ ❒ R ❒ L Breast

Was the nipple removed? ❒ Y ❒ N Was the surface skin of the original breast entirely removed? ❒ Y ❒ N

Any breast reconstruction? What was done? (ex. trans flap, implant) _____ ❒ R ❒ L Breast

Any breast radiation treatment? Date of last treatment _____ ❒ R ❒ L Breast

Are you currently pregnant? ❒ Y ❒ N Are you currently nursing? ❒ Y ❒ N

Are you CURRENTLY experiencing any of the following with your breasts: ❒ None

❒ Lump ❒ Thickening (date found _____; found by ❒ Self breast exam ❒ Doctor exam)

Pain: ❒ Dull ❒ Sharp ❒ Burning ❒ Stinging ❒ Tenderness ❒ The pain changes with my cycle

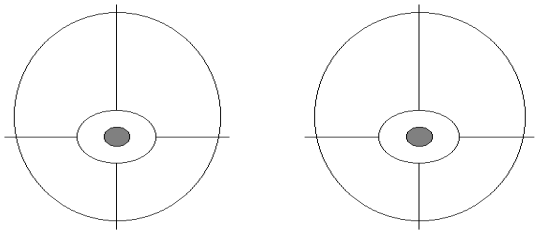
❒ Thickening ❒ Skin changes (❒ Color ❒ Texture ❒ Over the lump)

❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear ❒ Through 1 duct ❒ Through multiple ducts)

❒ R ❒ L Nipple retraction (❒ For many years ❒ Recently) ❒ R ❒ L Nipple changes (❒ Color ❒ Texture)

❒ Other _____

Place an [O] on the diagram in the area of the lump. [M] for a finding on your mammogram / ultrasound / MRI. [W] for an area being watched. [X] in the area of pain, tenderness, or skin changes. [#] in the area of thickening. [+++] in the area of a scar



RIGHT **LEFT**

❒ Re-Exam

High T:_____ Low T:_____ Tech: _____

Pt T = _____ F Rm T = _____ C ❒ R ❒ L Nipple retraction ❒ R ❒ L Areola traction SLQ SMQ ILQ IMQ

❒ R ❒ L Skin surface bulge or dimple SLQ SMQ ILQ IMQ ❒ R ❒ L Skin changes SLQ SMQ ILQ IMQ

❒ R ❒ L Nipple changes (❒ Color ❒ Texture) ❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear – S M)

CONSENT TO INFRARED IMAGING - THERMOGRAPHY

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. Since infrared imaging only detects heat at the surface of the body, the technology cannot see into the cranial vault, thoracic cavity, or deep into the body to visualize organs or bones. 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 my doctor for further imaging and/or proper treatment. _____

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 CT, MRI, or other types of 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 fully complied with the preparation protocol prior to imaging. _____

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/Guardian Name _____

Patient/Guardian Signature _____ Date _____

Witness _____ Date _____

INNOVATIVE
HEALTH & WELLNESS GROUP

EFFECTIVE MAY 1, 2020

CANCELLATION, LATE FEES AND NO-SHOW POLICIES

At Innovative Health & Wellness Group, we will always strive to deliver the highest standard and efficiency of care. To do this, we need your help! No shows and late cancelations inconvenience the individuals on our wait list who need access to the services rendered in our office in a timely manner. In an effort to reduce such occurrences, we are implementing the following cancellation and no-show policy that is effective immediately as of May 1, 2020.

PLEASE NOTE: due to COVID-19, we are unable to offer returns or refunds on any supplements, oils, or equipment purchased in our office. All sales are final.

We request you give our office 24-hour notice in the event you need to reschedule your appointment. Our office number is 214-972-0302 and our email is frontdesk2@evvdc.com. If an appointment is canceled within 24-hours of your scheduled appointment, a **$30.00 late fee** will be assessed to you. Our office works diligently to collect finalized labs, evaluating the results, and determining supplement recommendations that are personalized to you and your healthcare needs. Because of this, we require 48-hour notice if you need to reschedule lab work or diagnostic consultations. If 48-hour notice is not given, we will need to collect for the time that went into the preparation for that appointment and a **$50.00 fee** will be assessed to you. If you miss an appointment and do not give 24-hour advance notice, a **$50.00 no-show fee** will be assessed to you.

If you are late for an appointment, please know we will see you as soon as possible but your visit may be shortened in length. Additionally, if you are 10 minutes late to your appointment, a **$30.00 late fee** will be assessed to you. Our office makes reminder calls 24 hours before your scheduled appointment, or through text or email that you indicated preferences for on your intake paperwork. *It is ultimately the patient's responsibility to remember their scheduled appointments.*

This fee will be billed to you directly and is not covered by your insurance. If you don't have a future appointment scheduled, this fee will need to be collected in a timely manner and if not, will be subject to collections. We thank you for your support and understanding on this matter, and look forward to serving your healthcare needs in our office.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient