

FREETHERMALIMAGE .COM

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PLEASE PRINT CLEARLY

REFERRED BY: _____

Name _____ DOB _____

Address: _____

Phone: _____ Cell Phone _____

Emergency Contact: _____ Phone: _____

Email _____

I understand the report generated by my images is intended for use by a trained health care provider to assist in evaluation, diagnosis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis, or treatment.

I understand the report will not tell me whether I have an illness, disease or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Thermal Imaging Centers of America Integrative Thermal Imaging Services or any other entities such as those related above. I understand that my report will be sent to me via electronic mail. If by chance a email address is not available my report will then be sent to me via postal service. I also acknowledge that there is a fee of only five dollars should I need any additional copies of my report.

Authorization to use or disclose protected health information: as required by the privacy regulations, Thermal Imaging Centers of America, may not use or disclose your protected health information except as provided in our notice privacy practices with out your notification.

I hereby authorize Thermal Imaging Centers of America and any of its employees to use or disclose any patient health information to the following person(s), entity(s), or business associates of this establishment:

Thermal Imaging Centers of America
Integrative Thermal Imaging

Patient information authorized to be disclosed: thermal images and related health history.

For the specific purpose (describe in details) report of thermal findings and impressions of set images.

I understand that I have the right to:

Revoke this authorization by sending a written notice to this office and that revoking will not effect previous reliance on the uses or the disclosure pursuant to this authorization. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of 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 health plan or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

X _____ Date: _____

Signature of Patient or Patients Authorized Representative

FOR OFFICE USE ONLY: 1ST VISIT 3 MO RECALL 1 YR RECALL SUPERBILL (circle)

Description _____ Cost \$ _____ Drivers Lic# _____

Payment Method: Check # _____ Check \$ _____ Cash\$ _____

Credit Card # _____ ExpDate: _____

 Visa MasterCard Discover

Exact Name on Credit Card _____

Billing Address _____
 Street City State Zip

Signature Authorizing Payment