The Counseling & Gynecology Group, P.C.
175 Dwight Road, Suite 103
Longmeadow, MA 01106
Phone (413) 567-9355 Fax (413) 567-0011

Full Name: _____ Date of Birth: _____

Assignment of Benefits / Consent for Treatment, Payment & Health Care Operations

By signing below, I hereby authorize the practice to disclose my medical information so that the practice may treat, seek payment from third parties for such treatment, and generally carry on the practice's health care operations. I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to the Counseling & Gynecology Group. I also authorize the group to release all information necessary for the processing of insurance claims to the HCFA, its agents, or any other insurance company to determine benefits payable for related services.

_____ _____
Signature of Patient or Authorized Representative Date

Insurance Statement of Understanding, Copay Policy, Overdue Payment Policy

This office will gladly submit your private insurance claims for services rendered. You must supply your current ID card. All efforts will be made to collect your insurance benefits. Your insurance coverage is a contract and is your responsibility. You are also responsible for any non-covered services, as well as obtaining and maintaining a current referral, if necessary, and for any services denied by the insurance company. Many health insurance plans require a copayment, which is expected at the time of service. If we must bill you, a service charge may be added. Interest will accrue at the rate of 0.5% monthly on all accounts 60 days past due.

Prescription Refill Policy

Prescription refills require clinician approval. Prior authorization from your insurance carrier may be required. For these reasons, please ensure you are aware: gynecologic prescriptions require three days advance notice. Psychiatric prescriptions require seven days advance notice. ANY mail order or prior authorization prescriptions require fourteen days advance notice. This policy is necessary to ensure you will not run out of medication.

No Show / Cancellation Policy

If you cannot keep a scheduled appointment, please call one full business day in advance to avoid a cancellation fee. We reserve the right to charge a cancellation fee of $30-$60 for missed appointments. If you repeatedly 'no show' or cancel without sufficient notice, we reserve the right to discharge you from care.

Release Authorization I hereby authorize The Counseling & Gynecology Group to share information with:

Name: _____

Relationship: _____ Phone: _____

Information To Be Released to Individual Named Above

This section MUST be completed with permission about specifically protected health information as per M. G. L. c. 111 s70F-G. If you choose to share any of the following information, please write your initials on the line.

_____ I specifically consent to share information about ***medical appointments***
_____ I specifically consent to share information about ***medical billing and payments***
_____ I specifically consent to share information about ***HIV testing and/or treatment***
_____ I specifically consent to share information about ***genetic testing***
_____ I specifically consent to share information about ***alcohol and substance abuse***
_____ I specifically consent to share information about ***mental health***
_____ I specifically consent to share information about ***pregnancy, including abortion***
_____ I specifically consent to share information about ***sexually transmitted infections and treatment***

Revocation and Details of Release

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and/or state law.

I understand that I have the right to refuse to share my medical information with any other persons or people; my medical information will be kept private and confidential pursuant to HIPAA unless otherwise requested as above.

_____ _____
Signature of Patient or Authorized Representative Date

_____
If Signed by Authorized Representative, note relationship to patient here

New England Clinical Thermography *Incorporated*

Infrared Thermography - Breast Cancer Screening

Patient Education - Breast Screening

Purpose of test: For early detection of abnormal changes in the breasts requiring further diagnostic testing.

Patient preparation:

Do not smoke for 2 hours before the test.
Do not workout prior to imaging on the day of the test.
Do not use lotions or powder on your breasts or surrounding areas on the day of test. Note, this includes no use of underarm deodorant/antiperspirant.
If you must use, apply as little as possible and only directly in the armpit itself.
We will be imaging the upper back and neck so hair must be up off of the neck.
Please pin up or headband in advance or a headband will be provided when you come for imaging.
Avoid sun exposure on day of test – this includes tanning equipment. Recent, existing sunburns will also prohibit imaging(heat).
Diet - No changes necessary
Medicines - No changes necessary
Pregnancy – we do not image from conception until 3 months after the end of breast feeding due to all the breast changes going on, not due to any safety issue.
Read and completely fill out forms provided and bring with you on test day.

The Test

Enter imaging room, disrobe to waist, put on standard gown.
Allow time for body to acclimate to room temperature.
Thermographer will review paperwork for any issues.
Gown is removed for imaging of heat from bare skin which is blocked by any clothing.
5 Standard breast images are then taken, plus an extra front and back image.
Quick review of images by Certified Thermographer.
Dress.
Closing discussion to review any questions.
Disrobing - Remove all upper body clothing and jewelry. Put on surgical gown supplied.
Inform your Thermographer if you have had any recent skin lesions on your breast; the inflammation can cause a false positive result.

How the test will feel:

The room air may feel cool on your breasts as they adjust to room temperature before scanning. Examining room temperatures are comfortable when you disrobe for the examination. Any apprehension about the sophisticated thermography equipment is soon dispelled. The procedure is totally non- invasive, the camera does not emit radiation of any kind.

Time before test results available:

Time before results are reported to the doctor or patient varies from a few hours to a few days.

Frequently asked questions:

Who performs test? Female Imaging Technician
Any risks or side effects? None. Procedure non-invasive, non-contact, no radiation.
How long does it take ? Appointments are 30 minutes.
You are welcome to bring a companion or partner to be present at the examination
While participation in a DITI early detection program can increase your chance of detecting and monitoring breast disease, as with all other tests, it is still not a 100% guarantee of detection.

80 Fisher Road, Unit 82 Cumberland, RI 02864 401 475 5060 info@nemedtherm.com

New England Clinical Thermography

Breast Thermography Confidential Questionnaire

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

Name: _____ **MI:** ____ **Birthdate:** _____
Address: _____ **City** _____ **State** ____ **Zip** _____
Phone:_____ **Doctor:**_____

	Yes	No
1. Do you have any close relative who has had breast cancer?	___	___
If yes, which relative?_____		
2. Have you ever been diagnosed with breast cancer?	___	___
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	___	___
4. Have you had any biopsies or surgeries to your breasts?	___	___
<u>If you answer yes to any of questions 2, 3 or 4 you must complete page 2!!!</u>		
5. Have you had any breast cosmetic surgery or implants?	___	___
6. Have you had a mammogram in the past 12 months?	___	___
7. Have you had a mammogram in the past 5 years?	___	___
8. Have you had abnormal results from any breast testing?	___	___
9. Have you ever taken a contraceptive pill for more than 1 year?	___	___
10. Have you suffered with cancer of the womb?	___	___
11. Have you had pharmaceutical hormone replacement therapy?	___	___
12. Do you have an annual physical examination by a doctor?	___	___
13. Do you perform a monthly breast self exam?	___	___

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ **Your age at birth of first child:** _____
17. Did your periods start before the age of 12?_____ **Or finish after the age of 50?** _____
18. Do you smoke? (Circle) Yes Never Not in last 12 months Not in last 5 years

Have you <u>recently</u> had any of these breast symptoms:	**Right Breast.**	**Left Breast**
Pain	____	____
Tenderness	____	____
Lumps	____	____
Change in breast size	____	____
Areas of skin thickening or dimpling	____	____
Secretions of the nipple	____	____

<u>If you have any of the above symptoms, see page 2</u>

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.

Signature _____Today's date _____

Extended Breast Questionnaire

Patient Name: _____ Date:_____

Diagnosed with breast cancer:

Cancer type: _____ Local_____ Lymph node involvement_____
When diagnosed: Month_____ Year_____

Where:	**left breast**	**right breast**
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

Treatment: Surgery____ Chemo____ Radiation____ Other____ None____

Diagnosed with other breast disease:

Disease type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other ____
(please report other types of disease in the history)

Breast biopsies or surgery: (indicate which)

Where:	**left breast**	**right breast**
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

Dates of biopsies/surgery _____
_____

Result of biopsies/surgery_____
_____

Recent breast symptoms: Are they menstrual cycle related? Yes No (circle)
If not, how recently did they develop? _____

Any other comments on breast symptoms: _____
_____

New England Clinical Thermography *Incorporated*

Patient Information Sheet – If only Breast screening, history for that area is most significant.

Last Name:_____ First:_____ MI:_____

DOB _____ E-mail _____

Current Health Problems:_____

_____

_____

_____

_____

Medications:_____

_____

_____

Previous Illnesses/Injuries/Surgeries/Major Dental;_____

_____

_____

_____

_____

_____

Other Treatment:_____

_____

Family Illness History:_____

_____

_____

_____

Current Doctor:_____ Phone:_____

_____

Address:_____

How did you learn of imaging at this location? _____

This information is confidential.
All Information is correct to my knowledge.

Signed:_____ Date:_____

The purpose of this form is for the patient to authorize sending New England Clinical Thermography to send images to the interpretation service (EMI). They are a separate company and we cannot send your images and the accompanying medical history without your permission.

Authorization to Use or Disclose Protected Health Information to The EMI Interpretation Service

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, NECT 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 thermal images**

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period. **(Leave dates blank if you would like this authorization to be on-going.)**

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 on the uses 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 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 also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

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

_____ _____
Authorized Signature of Facility *Date*