Precision THERMOGRAPHY

1001 N. Meridian Rd. Meridian, ID 83642
Phone: (208) 563-0753

OFFICE POLICIES

Insurance Precision Thermography is not affiliated with any insurance company, and our providers are not in-network providers for any insurance company. We will not bill or submit claims to insurance or give a superbills for any imaging or imaging reports done by our office. This statement is provided voluntarily to make you aware of your financial responsibility upon receiving these services.

Health Savings Accounts Some of the services we provide may be covered by Health Savings Accounts, Flexible Spending Accounts and Idaho Medical Savings Accounts. It is your responsibility as a patient to know what your account covers.

End of Year Statement and Tax Information If you ask for itemized lists of payments in bulk it may take up to 30 days to fulfill your request.

Fee Structure At the time of scheduling a thermogram there will be a deposit that will go towards the cost of the thermogram. In the event that a patient does not show for their appointment and/or cancels their appointment the deposit will not be refunded. Patients will pay the remaining balance of the service after their appointment.

Payment Cards on File For convenience to both patients and staff, we require a debit/credit card number to keep on file, in the event that you need to pay for appointments, while not physically in our office. We do our best to get in contact with you prior to running your card in order to confirm charges. However, if we must leave a message when we call to take care of billing, and then do not hear from you, we will automatically charge your card at the end of the business day. Having a card on file does not negate the need to bring a physical card; we always prefer to run a physical card.

Questions for your Technician Phone calls, emails, and other communications outside of formal appointments take up staff time. Please allow 24 - 48 business hours for your message to be reviewed by an appropriate staff member and understand that we may not respond on the weekends.

Communications to our office with simple and clear questions relating to your thermogram reading, including importance of thermograms or other questions in regards to the thermogram process can be emailed to our office. Additional questions that are in regards to your medical wellness or directly referring to your imaging report, will be referred to licensed medical professional to review.

Behavior We make every effort to make your visit as pleasant and comfortable as possible. In turn, we ask that your behavior is respectful towards our staff and other patients. This includes vocabulary and behavior. There is a zero tolerance for abuse of any kind and this behavior may lead to dismissal from our practice.

If you have any problems associated with your visit, please contact LaNita Vance in writing at 1001 N. Meridian Rd., Meridian, ID 83642.

Patient's Name: _____ Signature: _____

Date: _____

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Notice of Privacy Policies

Patients Name: _____ Patients Date of Birth: _____/_____/_____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I hereby authorize Precision Thermography to share the following information:

_____ Images, reports and Health History _____ Appointment information _____ Both of these options

With the following people:

_____ Only release information to me personally.

Name _____Phone _____
Relationship _____

Name _____Phone _____
Relationship _____

_____ You have my permission to leave information on my answering machine or any other electronic communication (text, email, fax) regarding my medical care and reports.

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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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 I will be disrobed from the waist up for breast 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.

_____ I understand that Precision Thermography urges patients to follow health professionals' recommendations in response to thermogram results and is not responsible for any possible outcomes should I choose not to comply with those recommendations.

_____ 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's (Guardian's) Name:_____

Patient's (Guardian's) Signature:_____ Date:_____

Witness:_____ Date:_____

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ELECTRONIC COMMUNICATIONS AGREEMENT

LaNita Vance dba Precision Thermography ("we", "us" or "Practice") and the undersigned patient ("you" or "Patient") enter into this Electronic Communications Agreement ("EC Agreement") regarding the use of e-communications/ transmissions, such as e-mail, mobile or cellular telephone, text messaging, internet portal-enabled communications, or any other version of electronic communication (collectively "E-Communication") with respect to Patient personalized and protected health information ("PHI"). (Practice and Patient are each individually referred to as "Party" or collectively as "Parties".)

PATIENT AUTHORIZATION DESPITE RISKS OF PRIVACY BREACH

While electronic communication platforms and services are commonly relied upon to achieve communication immediacy, there are risks that you acknowledge that are outside the control of the Practice. You authorize all forms of E-Communications that are exchanged between the Parties unless you instruct us otherwise in writing. You acknowledge that the utilization of E-Communication is inherently risky and prone to unintentional release of data. E-Communications may incorporate or communicate references to your PHI with sensitive health and personal identification information included. You acknowledge that E-Communications lack any absolute guarantee of privacy and are subject to: system privacy failure, cookies and other tracking efforts, phishing attacks, hack attacks, data breaches, unintended misdirections, misidentifications of senders/recipients, technology failures, and user errors.

You agree to undertake efforts to protect your privacy, which includes refraining from including sensitive information in E-Communications that you do not want to be at risk of any data security breach. We will undertake reasonable efforts to protect your privacy to the extent required by applicable laws. You authorize us to respond electronically to all E-Communications that appear to be provided by you, whether or not such communications actually arrive from the electronic contact information that you provide us.

PATIENT MUST PROVIDE ACCURATE and UPDATED CONTACT INFORMATION

You agree to provide us with your accurate electronic contact information (mobile telephone number, email address, Skype or FaceTime contact information, and any other applicable E-Communication contact information). You will immediately inform us of any changes or corrections to your electronic contact information as an effort to avoid misdirected E-Communications.

PATIENT MUST NOT RELY ON ELECTRONIC COMMUNICATION IN EMERGENCIES: USE 911 AND GET TO THE EMERGENCY ROOM

We do not guarantee that we will read your E-Communications immediately or within any specific amount of time. You agree **not** to utilize E-Communications to contact us regarding an emergency or time-sensitive situation, as there is too much risk that the communication response may be delayed, ineffective, untimely, or inadequate. **You MUST call 911 in any emergency, and/or must immediately seek emergency medical attention.**

PRACTICE WILL COMPLY WITH HIPAA

The Practice values and appreciates your privacy and will take commercially reasonable steps to protect Patient's privacy in compliance with the Health Insurance Portability and Accountability Act of 1996 and related laws ("HIPAA").

We will obtain your express written or electronic consent (to the extent required by applicable law) if we are required or requested to forward your identifiable PHI to any third party other than as authorized in our Notice of Privacy Practices or as authorized or mandated by applicable law.

You hereby consent to the use of E-Communication of Patient's information as we consider helpful to coordinate care and schedule office visits with you and all parties responsible for providing or overseeing your care. You agree to identify individuals or entities authorized to receive your PHI from us in connection with authorized consulting, education, and all other aspects of your care, and we may share your PHI with such parties without additional written or electronic consent from you.

You have the right to ask us for a copy of your PHI, including an explanation or summary. The following services that we perform will not be the subject of additional charges to you: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information.

We may charge you fees for actual costs that we incur to provide such electronic PHI, but only to the extent authorized by applicable laws. Such fees may include to the extent lawful: skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs charged to you; and time spent by our administrative staff preparing additional explanations or summaries of PHI. If you request PHI on a paper copy, or portable media (such as compact disc (CD), or universal serial bus (USB) flash drive), we may charge you for our actual supply costs for such equipment, and you agree to pay us any such costs.

PATIENT ACCEPTS RESPONSIBILITY FOR ELECTRONIC COMMUNICATION RISKS

You will hold Practice (and our owners, officers, directors, agents, and employees) harmless from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney fees, arising out of or caused by E- Communication (whether encrypted or not) losses or disclosures caused by any of the risks outlined above, or caused by some person or entity other than Practice, or not directly caused by us. Patient acknowledges and understands that, at our discretion, E- Communication may or may not become part of your permanent medical record. Practice is not relieved by these terms from Practice's obligations to comply with all applicable E-Communication laws.

You acknowledge that your failure to comply with the terms of this EC Agreement may result in our terminating the use of E-Communication methods with you, and may result in the termination of your agreement for our services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you a copy of our Notice of Privacy Practices, which states how we may disclose your PHI. You hereby acknowledge receipt of the Notice of Privacy Practices.

Consent to disclosure of billing information - By signing this EC Agreement, you consent to the disclosure of all information relevant to billing, insurance and reimbursement regarding any and all substance abuse disorders that you might have, for the purpose of obtaining reimbursement from private or public insurers.

ADDITIONAL TERMS

This EC Agreement will remain in effect until either Party provides written notice to the other Party revoking this EC Agreement or otherwise revoking consent to E-Communications between the Parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation.

Revocation of this EC Agreement will preclude us from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by you. Either Party may use a copy of this signed original EC Agreement for all present and future purposes.

Parties agree to take such action as is necessary to amend this EC Agreement from time to time as is necessary for us to comply with the requirements of the Privacy Rule, the Security Rule, and other provisions of HIPAA, or other applicable law.

Parties further agree that this EC Agreement cannot be changed, modified or discharged except by an agreement in writing and signed by both Parties.

If any term of this EC Agreement is deemed invalid or in violation of any applicable law or public policy, the remaining terms of this EC Agreement shall remain in full force and effect, and this EC Agreement shall be deemed amended to conform to any applicable law. The construction, interpretation, and performance of this EC Agreement and all transactions under this EC Agreement shall be governed by the laws of the state where the Practice is located, excluding choice-of-law principles.

Each participating patient over the age of 21 is required to sign this EC Agreement. Your signature represents that you understand and agree to the terms and conditions described within this EC Agreement.

PRACTICE:

LaNita Vance dba Precision Thermography

By: _____ LaNita Vance

Date: _____

PATIENT (OR AUTHORIZED REPRESENTATIVE OF PATIENT):

Sign: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

Precision
THERMOGRAPHY

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HIPAA Secure Email

It is the policy of Precision Thermography to comply with the requirements set down by the Health Insurance Portability and Accountability Act (HIPAA) with regard to electronically transmitted (email) protected health information (ePHI).

This form is to inform you that in order to protect your health information we have contracted with a HIPAA compliant encrypted email services. While we have taken reasonable precautions regarding the email transmission of your ePHI, it is not possible to protect against every unforeseen occurrence. this means that even though your ePHI will be sent encrypted there is a remote possibility that a third party may be able to access the information and read it. As such, Precision Thermography is NOT responsible for unauthorized access of your PHI while in transmission to you. Further, Precision Thermography is NOT responsible for safeguarding the information once the email is received by you.

The steps we take to safeguard your ePHI are as follows:
We verify that the email address you supplied is correct.
A password will be necessary to access the emails sent from our HIPAA compliant encrypted email service.
Once the password is authenticated, all reports, attachments, and written health care information will be encrypted end-to-end using the contracted service's own serves.

I fully understand all the risks, and have had all my questions satisfactorily answered, regarding the sending of my ePHI and do hereby give my permission to Precision Thermography to send me personal Health information via encrypted email. I will not hold any of the authors, contributors, administrators, the Precision Thermography or LaNita Vance in any way whatsoever responsible for any exposure of my person health information.

Signature: _____ Date: _____

Print Name: _____

Please print email address: _____