Dr. Vera Singleton, ND, MBA
953 Mountain View Drive
Lafayette, CA 94549
510-230-2282

Healthy Options, Inc.
PO Box 111
Victoria, Mn 55386
650-219-2036

Patient Information:

Digital Infrared Thermal Imaging (Thermography)

Purpose of test:

To define a previously diagnosed injury or condition.
To identify an abnormal area for further diagnostic testing.
To follow progress of healing and rehabilitation.
To provide objective evidence.
For the early detection of lesions.
For early detection of abnormal changes in the breasts requiring further diagnostic testing.

Patient preparation:

Do not use creams, lotions, deodorants, talcum powder of other skin product on breasts.
Do not perform any rigorous exercise program for at least four hours prior to screening.
Do not bathe or shower in HOT water for at least 4 hours prior to screening.
Please avoid direct stimulation to area of interest including shaving, other forms of hair removal, scratching (if possible), etc. Also avoid breast & nipple stimulation 24 hours prior to screening.
Do not smoke or use products containing nicotine the day of your screening.
Do not drink coffee, tea, soda or other beverages containing caffeine 4 hours prior to screening.
Avoid having medical breast procedures, physical therapy, analgesic creams, balms or magnets 24 hours prior to screening. (Discuss with your physician before discontinuing any of the above).
You cannot be sunburned or have a fever at the time of your examination. If you are lactating, your readings will not considered as baselines.
Diet – No change necessary.
Medicines – No changes necessary.

<u>The Test</u>

Equipment used:

Thermal imaging scanner. The procedure is non invasive and does not emit any radiation.
Screening is performed by a clinical thermographer.

Description of test:

Patient time for the test: 30-45 minutes.
A surgical gown will be provided for disrobing – removing all upper body clothing and jewelry.
The room air may feel cool as your skin equalizes to the room temperature.
Inform thermographer if you have any recent skin lesions on your breasts.

Time before test results are available:

Typically the time varies between 5 and 10 days, depending on postal delivery service.

<u>Post Test</u>

Immediate post-test care:

None required.

Additional tests and studies:

Your healthcare practitioner may require further investigation to establish a diagnosis. These tests may include mammography, X-ray, ultrasound, electromyography, myelography, MRI or CT scan.

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 testes, it is still not a 100% guarantee of detection.

Informed Consent

Scott Cheshaek of Healthy Options Inc. is certified as a thermographic technician, under The American College of Clinical Thermology. The Supervising practitioner or clinic is: ____Dr. Vera Singleton, ND_____

Fees for services: breast screenings $_____ region of interest scans $_____

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Thermographic Disclosure

I understand thermographic imaging is a non-invasive technique providing a visual image that graphically maps the bodies temperature spectrum providing a unique profile of physiological patterns. Thermography is designed to help, among other things, identify breast tissue abnormalities. This procedure detects subtle physiologic changes in tissue temperature that accompany pathology.

Unlike mammograms and ultrasounds which assess anatomical changes in tissue, thermography is an assessment of physiological changes. As such, the findings of any given report, may state that further investigation or correlation may be warranted, suggested or required. In this case, it is to be determined between you and your primary health care provider or supervising clinician whether to proceed with a routine physical, mammogram, ultrasound, biopsy or other medical procedure or exam. _____ (*initial).*

Worldwide clinical trials and studies have determined thermography to be highly accurate, Thermography has been shown to be between 82-97% effective in determining early stage physiological changes, inflammation and neogenisis, with only 17% of developed tumors being potentially thermographically silent. Compared to mammograms which have shown to produce up to 60% or higher false positive readings. Neither thermography, mammograms, ultrasound or any other screening method is a 100% guarantee of detection. All these methods are intended as pre-screening procedures and are not intended as diagnostic procedures. I understood that under legal statutes Thermography is an adjunctive assessment and all interpretive findings must be clinically correlated. I also understand that only a medical doctor can rightfully determine if an individual has breast cancer, as breast cancer can only be determined via a biopsy. _____ *(initial)*

Creating a Baseline

For all first time clients, Meditherm recommends a three month follow up to the original thermogram in order to obtain an accurate baseline pattern. This provides a comparative study showing indications of any changes in physiology and also monitors stability. Once a stable baseline is determined this establishing a pattern to which all future thermograms are compared.

Procedure

The screening procedure will be performed by Scott Cheshaek of Healthy Options Inc., certified under The American College of Clinical Thermology and trained as a thermographic technician,

The time duration for this procedure is approximately one half hour. I the undersigned understand and acknowledge that every effort has been made available to provide a safe and comfortable environment for this procedure. If at any time I feel uncomfortable, I may request that the procedure be stopped or terminated or that reasonable changes be made to provide a more comfortable procedure, including asking for a third party to be present during the screening.

The images and client questionnaire from this session are electronically transferred to Meditherm Inc. This information is assessed by board certified Medical Doctors for interpretation. Assessment reports are electronically returned to Scott Cheshaek at Healthy Options, Inc. along with the session images. The report and images will be printed and sent to the medical clinic where services were rendered or directly to client upon signing of medical correlation waiver.

Disclosure

It is understood that the thermographic technician is not an interpreter and will not be asked, or placed in the position of making statements about the thermographic images before, during or after any session. Any further questions or concerns of the imaging or upon receipt of the images or reports are to be directed to the hosting practitioner or other health care provider.

I the undersigned further understand and accept to not hold the thermographic technician personally or legally liable in any way for any conclusions or assessments that may arise as a result of either the image screening or report interpretations.

In signing this form I acknowledge that I have voluntarily chosen to participate in the thermal imaging procedure as part of my own health care prevention. I further acknowledge that I understand I have choices in which procedures of health care I may participate in and that I may seek other means of related services at my own volition and that I have the option to refuse services at any time.

Payments

Fees for services are due in full and paid at the time of service. Payment may be made by cash, check or credit card (Visa or Master Card only). It is understood that any returned checks or declined credit cards will delay delivery of the report and images until payment is made in full. Returned checks are subject to a $25.00 service fee. Upon request a cash receipt for services can be provided. Super bills or documentation for insurance coverage are to be requested and obtained from the hosting clinic.

Agreement

The following is an agreement between the client and the thermographer and/or other licensed health care providers who interact with the client while working with or associated with the provider rendering thermographic services, including those working at the provider's clinic or office. By signing this agreement it is agreed that any dispute including medical malpractice is to be resolved in binding arbitration. All claims for monetary damages against the health care provider, thremographer and /or the health care provider's associates, corporation, partnership, employees, agents and estate must be arbitrated. I understand that by signing this contract I am agreeing to have any dispute, that is to whether any services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration in the state of California, as provided by the California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a judge, jury or other legal entity, and instead are accepting the sole use of arbitration.

This agreement is intended to bind the client and the thermographer, health care provider, associates, partnerships, employees, agents and estate, to arbitration including, without limitation, claims for loss of consortium, wrongful doing, emotional distress, injunctive relief, or punitive damages.

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator within thirty days and a third arbitrator (neutral arbitrator) shall be selected by these arbitrators and appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including expenses incurred by a party for such party's own benefit. I agree that in the event no findings are found by or against the provider (thermographer), all fees for arbitration will be paid in full by plaintiff. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

By signing this agreement I agree to retroactive effect of all prior visits, contact and screening, effective as the date of first professional services. I understand and agree to the forgoing agreement.

Printed Name:	
Signed:	Date:

Name:	Birthdate:		
Address:	City:	State:	Zip:
Email:	Phone:	Doctor:	

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.

Breast Thermography Confidential Questionnaire

	Yes	No	
Have you had a breast thermography before	☐	☐	Where _____
1. Do you have any close relative who has had breast cancer?	☐	☐	Who _____
2. Have you ever been diagnosed with breast cancer?	☐	☐	
3. Have you ever been diagnosed with any other breast conditions (fibrocystic)?	☐	☐	
4. Have you had any biopsies or surgeries to your breasts?	☐	☐	
5. Have you had any breast cosmetic surgery or implants?	☐	☐	When_____
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?	☐	☐	When _____
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? Yes: ☐ No: ☐ Or finish after the age of 50? Yes: ☐ No: ☐

18. Do you smoke? Yes: ☐ Never: ☐ Not in last 12 months: ☐ Not in last 5 years or longer: ☐

Have you recently 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	☐	☐

Location of any marks on the body in the area being scanned (scars, tattoos, moles, etc.) _____

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. In order to establish an accurate baseline pattern, Meditherm recommends a three month follow up thermogram. The purpose of the three month comparison is to establish a baseline pattern for which all future thermograms are compared for monitoring stability. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signed: **Date:**

Authorization to Use or Disclose Protected Health Information

Healthy Options, Inc.

Name:	
Address:	
Date of Birth:	Date of Request:

As required by the Privacy Regulations, *Healthy Options, Inc.* 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: **Interpretation of said images**

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above 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 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*

Extended Breast Questionnaire

ONLY TO BE COMPLETED IF THERE IS A HISTORY OF BREAST CANCER

Patient Name:	Date:
Have you had a thermogram before? Yes ☐	No ☐
If so where?	When:

Diagnosed with breast cancer:

Cancer type:	Metastatic: ☐ Local: ☐ Lymph node involvement: ☐
When diagnosed:	Month: Year:
Where (left breast):	Upperouter ☐ Upperinner ☐ Lowerouter ☐ Lowerinner ☐ Nipple ☐
Where (right breast):	Upperouter ☐ Upperinner ☐ Lowerouter ☐ Lowerinner ☐ Nipple ☐
Treatment:	Chemo ☐ Radiation ☐ Other ☐ None ☐

Diagnosed with other breast disease:

Disease type:	Fibrocystic ☐ Cystic ☐ Mastiti ☐ Abscess ☐ Other ☐

Breast biopsies or surgery:

Biopsy: Yes ☐ No ☐ **Surgery:** Yes ☐ No ☐	
Where (left breast):	Upperouter ☐ Upperinner ☐ Lowerouter ☐ Lowerinner ☐ Nipple ☐
Where (right breast):	Upperouter ☐ Upperinner ☐ Lowerouter ☐ Lowerinner ☐ Nipple ☐

Thermal Medical Imaging, Inc.

Thermogram Follow Up Referral

Thermography is a safe non-invasive method of evaluation of physiological changes and early detection for many. By using infra-red imaging, areas related to inflammation, increased or decreased blood flow, neogenesis and other physiological abnormalities can be detected and monitored. This method is a means of monitoring pre-existing conditions and their progression or regression relative to current treatment protocols as well as detecting changes in physiological conditions.

The benefits and value of thermography have been established and well documented in helping to determine or distinguish physiological abnormalities. To date, the conventional allopathic medical community has not established Thermography as a replacement for conventional assessment techniques such as Xray, ultrasound, MRI, mammograms regular health examinations and evaluations. Therefore, you agree it will be your responsibility to follow up with a qualified medical provider regarding any change in thermal patterns, unusual or suspicious results that may appear, be presented, suspect or stated on the thermography report.

Thermography is suggested as part of your regular maintenance of good health care. After the initial base line, thermograms are recommended on an annual basis to monitor for physiological changes.

Name of your primary health care provider: _____

Providers Phone Number: _____

Signature: _____ Date: _____

Print: _____