TOTAL THERMAL IMAGING OF TEMECULA
Patient Consent and Billing Information

Please Print Clearly Referred by_____

Name_____DOB_____

Mail Address_____City_____Zip_____

Hm.Phone ( )_____Mobile ( )_____

Email (for report and receipts)_____

In case of emergency contact_____Phone ( )_____

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 ***Total Thermal Imaging of TEMECULA (TTI of OC)*** and ***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 email. 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) $5.00 dollars should I need any additional copies of my report.
Authorization to use or disclose protected health information: as required by the privacy regulations, ***TTI of TEMECULA*** may not use or disclose your protected health information except as provided in our notice to privacy practices without your notification.
I hereby authorize ***TTI of TEMECULA*** and ***Integrative Thermal Imaging Services*** and any of it's employees to use or disclose any patient health information to the following person(s), entity(s), or business associates of this establishment:
TTI of TEMECULA and ***Integrative Thermal Imaging Services*.**
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 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 of 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 Patient's Authorized Representative

(This line for office use) 1st Visit 3mo recall 6mo recall 1yr recall **SUPER-BILL**

Description of screening_____Cost $_____

Payment method Cash_____Check #_____Credit Card #_____
M/C / Visa / Debit / Discover

Name on Credit Card_____Exp.Date_____3-Digit Sec.#_____

Billing address (if different than above)_____

Signature Authorizing
Payment_____Date_____