THERMAL IMAGING CENTERS
OF AMERICA

623-243-7100

thermalimagingcenters.com

19420 N. 59th Ave, Suite C-273, Glendale, AZ 85308

PRE-SCAN INSTRUCTIONS

Purpose of test:

Detection of inflammation, lymphatic congestion and hormone imbalance which are the precursors to disease and dysfunction. Early detection of abnormal changes in the physiology of the entire body, including the breasts, can be seen via thermal imaging. It is possible that these changes may or may not require further diagnostic testing dependent upon the findings via the medical interpretation by our board certified thermologist.

Preparation Prior to Thermography Screening:

3 Months Prior

- No major surgery, chemotherapy or radiation

1 Month Prior

- No minor surgery or any biopsies of any kind

One week (7days) Prior

- Avoid sunburning. No tanning or tanning booth treatments

3 days Prior

- Shave any thick body hair (for men, the chest, shoulders, back, etc.)as the camera can not calibrate images through thick hair

2 days Prior

- No heavy alcohol consumption (or hangovers)
- No x-ray mammography

1 Day Prior

- No extensive exercise and avoid overheating (running, gym workout, sauna, etc.)
- No physical therapy, chiropractic treatments, acupuncture, massage, diathermy, electrical muscle stimulation (EMS), nerve stimulation(TENS), or heat/cold therapies

After Midnight Prior

- No alcohol consumption
- If possible, wait until after your thermal scan to take any prescription medications, especially blood pressure or circulation medications. If you have any questions, please consult with your primary care physician

Day of

- No exercising
- No lotions, powders or creams (including hormone creams)
- No deodorants or antiperspirants

4 Hours Prior

- No supplements or non prescription medications (especially cold remedies and niacin)
- No very spicy foods

2 Hours Prior

- No smoking or use of nicotine delivery products (snuff, gum, patches, electronic cigarettes, etc)
- No caffeine or nicotine

1 Hour Prior

- No eating or drinking anything
- No breastfeeding

Actual Procedure:

- Please wear loose clothing with hair pulled back
- You will be asked to disrobe and uncover the areas we will image.
- Please identify if you have any lesions, bruises, rosacea or any skin disorders
- To receive accurate results, the equilibrating time is 15 minutes and the temperature will be 68-72 degrees.
- You will be asked to disrobe according to the type of scan we are performing
- Reports are generally received within 5-7 days after your initial visit
- Please print and complete the following two patient in-take forms and bring them to your appointment

We look forward to seeing you!

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PATIENT CONSENT FORM

Name:____DOB:__________
ADDRESS:____
CITY/STATE/ZIP:____
PHONE:____
EMAIL: ____
SCAN TYPE: _______Full Body _______Half Body _______Breast/Lymph _______Spot View
How did you learn about Thermography?_______________________________
How were you referred to Thermal Imaging Centers of America™?________________

I understand the report generated by my images is intended for use by a trained healthcare 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, cancer or any other condition but will be an analysis of the images with respect to the thermographic findings of the areas discussed in the report. By signing below, I knowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information to the reading doctor and the receipt of information from the reading doctor in pursuit of comprehensive evaluation and treatment relating to the services provided by Thermal Imaging Centers of America/Total Thermal Imaging. I understand that my report will be sent to me via electronic mail. If an email address is not available, my report will then be sent to me via US Postal Service.

Authorization to use or disclose protected health information is required by the privacy regulations. Thermal Imaging Centers of America and Total Thermal Imaging may not use or disclose protected health information without my consent.

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: Total Thermal Imaging and/or Dr. Gregory Melvin, DC, BCCT (our primary reading doctor).

Patient information authorized to be disclosed: thermal images and related health history for the specific purpose of a report of thermal findings and impressions of set images.

I understand that it may be possible that my image(s) may be used for the purpose of marketing, training or education however, my identity will be protected according to HIPPA and other identity protecting regulations.

I understand that I have the right to refuse to sign this consent or revoke this authorization by sending a written notice to this office and that not signing or revoking will not affect previous reliance on the uses for the disclosure pursuant to this authorization. I also understand that if I do not sign this document, it will not impact my treatment, payment, enrollment in health plan or eligibility for benefits in any way.

Signature:____Date:_________

Print Name:____

Masters of Healing

Gregory Melvin D.C., B.C.C.T.

7339 El Cajon Blvd. Ste. H , La Mesa CA. 91942 Ph.619-834-2644

Name: ______________________________ Birth Date: __________

Address: ______________________ City: ______________ State: ________ Zip: ________

E-Mail: ______________________ Home Ph. # ______________ Cell Ph.# ______________

Emergency Contact (Name/Tel) ______________________________ Last Thermogram __________

Breast Questionnaire - Receive the report: In person/ Mail/ E-Mail Occupation:________________ Referred by:_______________

have you had the following:

Diagnosed with breast cancer? **Yes / No**

If yes: **type- Metastatic /Lymphatic Node removal / Local** *When*: / /

Diagnosed of other breast disease? **Yes / No**

____

Biopsies and your findings? / / **Yes / No**

____

Breast surgery/ implants? / / **Yes / No**

Mammogram last 12 months? **Yes / No**

Total # Taken _____First Taken? / /

Contraceptive over 1 year? **Yes / No**

Hormone therapy? **Yes / No**

Doctors last breast exam? / /

Monthly breast self exams? **Yes / No**

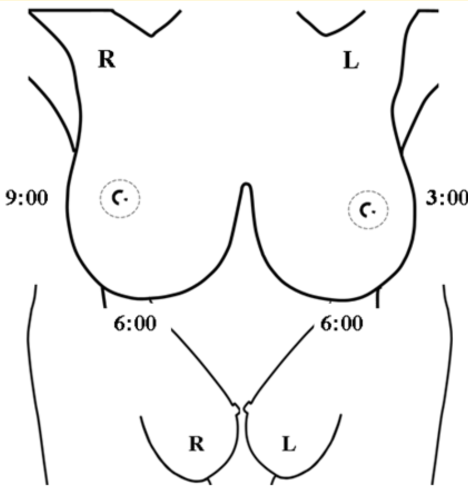
Menstrual periods before 12? **Yes / No**

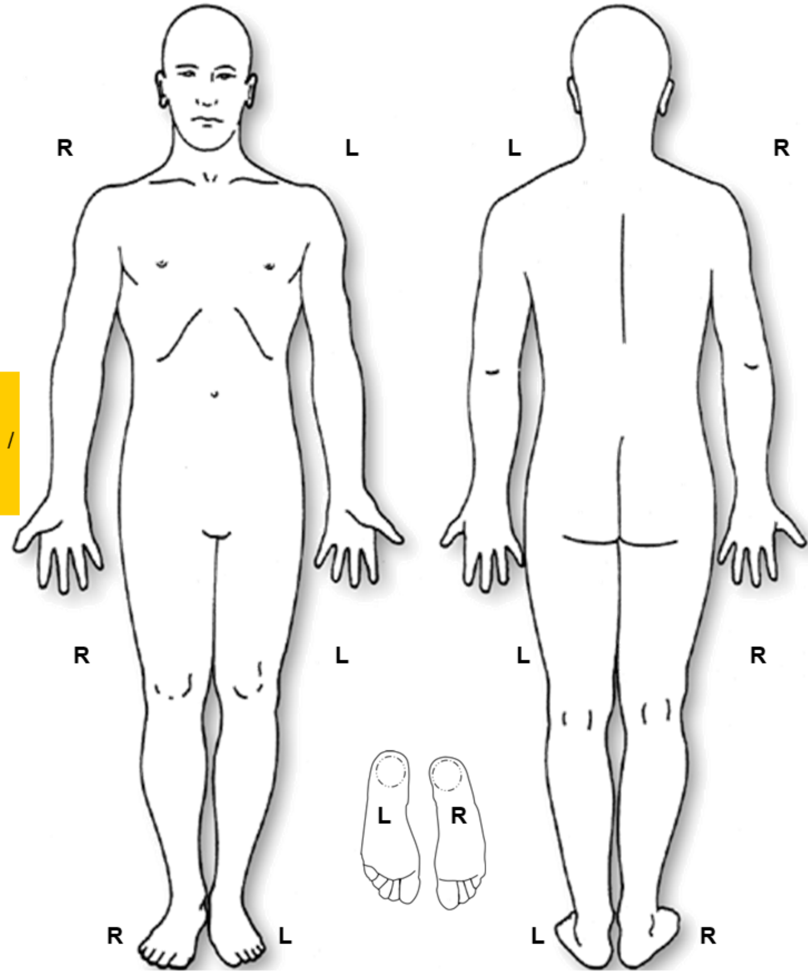
Menstrual stopped after 50 ? **Yes /No**

Total # births?____, your age of first born? _____

Please demonstrate symptoms with the following symbols with accurate locations on the body figure below: "**N**" for **n**umbness; "**1-10**" for pain **10** being the **worst**; "**S**" for **s**cars; "**M**" for **m**oles; "**F**" for **f**ractures; "**X**" for previous surgeries or current/prior diseases with a line to a brief description.

Breast symptoms in the last 6 months? Please demonstrate symptoms with following symbols: "**T**" for **T**enderness; "**L**" for Lumps; "**D/T**" for Nipple **D**impling / **T**hickening. **Change** in **Size** "**CS**"; "**NS**" **N**ipple **S**ecretion, **Biopsy** "**B**", presently breast feeding: ***Yes / No***





Main complaint: ______________________________

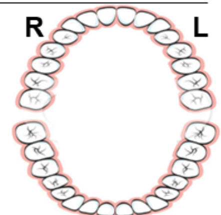
____

____

____

Current Medication: ______________________________

____



Teeth/ Gum symbols of history: please use the following letters when marking the areas of the mouth: **R**oot **C**anal "**RC**"/**C**rown "**C**"/**S**urgery "**S**" **M**ercury **F**illings **MF/O**

Client Disclosure: *I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, analysis 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 Gregory Melvin, DC and* ***Masters of Healing. We are hereby exercising our right of freedom of association. This means that our association activities are restricted to the private domain only and outside the government entities, agencies, officers, agents, contractors and other representatives as provided by law.***

Client Signature : ______________________________ *Date:* __________

Signature Authorizing Payment