bloomington wellness center

# *Thermography Intake Form*

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**wellbloomington.com**

## Client Data Form

**Date: ___ /___ /201____**

Name _____ Preferred Name _____

Address _____City_____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone _____

Email _____ Referred by _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Gender M / F

Emergency Contact **(If Spouse or Child, Circle Below)** _____ Phone _____

Spouse Name _____ Phone _____

Children (name(s) & age(s))_____

## Consent to provide Thermography services to a minor child (through age 18)

I, _____ , being the parent or legal guardian of _____

hereby grant permission for my child to receive healthcare services.

**Initials: _____**

## Cancellation / Missed Appointment Policy:

A 24 hour notification is required for appointments that need to be cancelled. If proper notification is not given, a **$30 charge** will be applied to your account and is due within 15 days of the missed/cancelled appointment.

**Initials: _____**

## Authorization to use/disclose Protected Health Information (PHI):

PHI to be disclosed: **Thermal images & related health history**. I hereby authorize the release of my PHI for the purpose of interpretation, education or marketing to the following person(s), entity(s), or business associates of: **Bloomington Wellness Center and Physicians Insight, LLC.** I understand that my anonymity will be maintained.

Please provide my thermography report to me via: **Email or Mail** (circle one) to the address listed above.

**Initials: _____**