



## INFORMED CONSENT FORM

Please read the following and sign below:

I understand:

Prismatic Medical Thermography and its staff of certified thermographers will use Digital Infrared Imaging (DITI) to take images of specified regions of my body as requested

These images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.

My images will be interpreted by \_\_\_\_\_

The Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.

DITI is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.

The Report will not tell me whether I have any illness, disease or condition, but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.

DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI, etc)

I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore, I hold Prismatic Medical Thermography harmless as to the results and interpretations resulting from this process.

Prismatic Medical Thermography will keep all information shared by me completely confidential unless I provide a release in writing or as required by law.

### Acknowledgement

By signing below, I certify that I have read and understand the statements above and consent to the examination.

\_\_\_\_\_

Name (please print)

Date of signing

Date of birth

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Name, if other than client, and relationship to client.