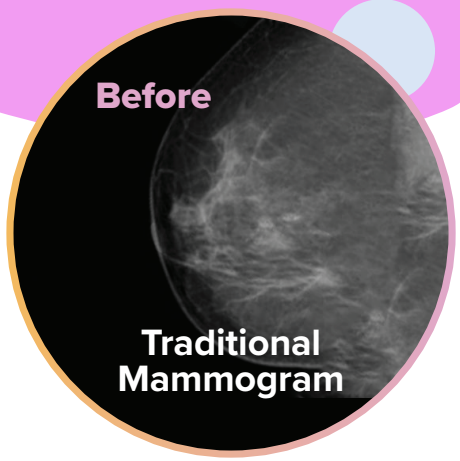
gnosis for her

A New Diagnostic Option When Mammography Isn't Enough.

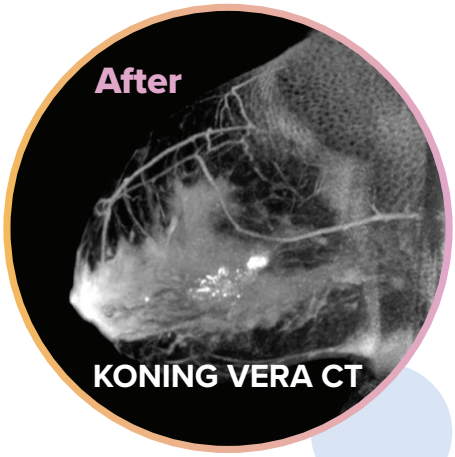


Gnosis for Her is a mobile diagnostic breast imaging provider offering 3D Breast CT to local communities. Breast CT delivers true isotropic 3D visualization of the entire breast **without compression**, supporting improved evaluation for dense breast tissue, around implants, and in cases where traditional mammography is inconclusive.

Who Qualifies for Breast CT?

3D Breast CT is a diagnostic alternative, not a replacement for to traditional mammography. Physicians consider Breast CT for women who:

- Have dense breast tissue or implants where traditional mammography may be limited
- Experience pain, intolerance, or delayed imaging due to compression
- Present with palpable lumps, nipple changes, or focal pain
- Prior mammography was abnormal or inconclusive
- Have a personal or family history of breast cancer
- Additional diagnostic clarity is needed before biopsy or follow-up



Why Providers Are Adopting Breast CT

Breast CT helps reduce diagnostic uncertainty when mammography is limited.
For appropriate patients, it supports clearer clinical decision-making, fewer inconclusive results, and efficient coordination of follow-up, without adding unnecessary burden to the referring practice.

Key advantages for providers:

- High-resolution, true isotropic 3D imaging of the entire breast, axilla, and chest wall
- Improved visualization in dense breast tissue, implants, and post-surgical anatomy
- <1% technical callback rate, reducing repeat imaging
- Clearer evaluation of small calcifications, vascular, and subtle findings
- Faster and lower-cost alternative to MRI, helping reduce delays in follow-up
- High patient tolerance → improved compliance
- Radiation exposure comparable to traditional mammography

What Happens If a Follow-up Is Needed?

If further evaluation is indicated, follow-up imaging or procedures may be recommended based on clinical judgment. This may include MRI, contrast-enhanced mammography, DBT, or CT-guided intervention.

Results are communicated to both the ordering provider and the patient, ensuring timely, coordinated care.

CONNECT WITH US

If you have any questions, our Care Team is available at 888.311.5220 and support@gnosisforher.com.

gnosis for her

GNOSIS FOR HER
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PATIENT INFORMATION			REFERRING PROVIDER INFORMATION	
First Name:	Last Name:	MI:	Provider Name:	NPI:
DOB:	Sex: M F	Phone:	Facility/Practice Name:	
Email:			Street Address:	
Street Address:			City:	State: Zip:
City:	State:	Zip:	Phone:	Fax:

INSURANCE INFORMATION ☐ See Attached List

Insurance Name:	Policy #:	Group #:
Insured First Name:	Insured Last Name:	Relationship:
Street Address:	City:	State: Zip:

SERVICES (ALL SERVICES WITHOUT CONTRAST) (SELECT ONE SERVICE)

☐ Bilateral without contrast: 0636T ☐ Unilateral without contrast: 0633T [☐ LT [☐] RT

DIAGNOSIS CODES (ICD-10 CODES)

RISKS AND INDICIATIONS (Select all that are applicable)

History of Cancer:
- ☐ Yes ☐ No
- Date of diagnosis: _____
- ☐ Left Breast ☐ Right Breast

Breast Symptoms:
- ☐ Lump
- ☐ Pain or tenderness
- ☐ Focal pain (Location: _____)
- ☐ Nipple discharge
- ☐ Skin changes (e.g. redness, dimpling)
- ☐ Nipple inversion
- ☐ Dense breasts
- ☐ Rash
- ☐ Swelling (Location: _____)
- ☐ Thickening (Location: _____)

Risk Factors:
- ☐ Family history of cancer
- ☐ Known BRCA1 or BRCA2 gene mutations
- ☐ History of chest radiation therapy before age 30
- ☐ Certain genetic syndromes
- ☐ African descent
- ☐ Ashkenazi Jewish descent
- ☐ Age
- ☐ Estrogen levels

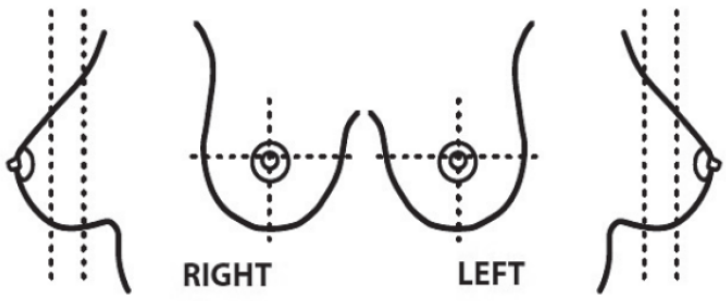
Implant Evaluation:
- ☐ Suspected rupture
- ☐ Preoperative planning
- ☐ Suspected abscess
- ☐ Implants

Follow-Up / Known Findings:
- ☐ Six-month follow-up (BI-RADS 3)
- ☐ Biopsy-proven benign mass or density
- ☐ Findings on prior Mammogram (Date: _____)

Imaging Limitations:
- ☐ Non-compliant with standard mammography

Other (Please specify):
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

AREAS OF CONCERN (Please mark all area(s))



CONFIRMATION OF INFORMED CONSENT & MEDICAL NECESSITY

The results of this test are medically necessary for the diagnosis, risk assessment, or detection of illness, disease, symptom, disorder, or syndrome. This test will produce results that will support the management and treatment decisions for my patient's condition. I hereby indicate that I am the authorized healthcare provider and referring physician for this test. I have acknowledged and support the patient's right to refuse testing and have offered the patient opportunities to ask questions as well as the opportunity to seek further counsel. The patient has chosen to take this test on their own accord and willingly selected Gnosis for Her to perform this test. I acknowledge my responsibility as the patient's physician to record all applicable ICD-10 diagnosis codes.

X _____
Physician Signature and Date