PATIENT REGISTRATION

Hyperbaric Health Services
Palatka
524 Zeagler Drive
Palatka, Florida 32177
(386) 385-3857
fax (386) 530-2052
HyperbaricsPalatka@gmail.com

PERSONAL INFORMATION

First Name | Middle Name | Last Name

Date of Birth | Age | Race

Male / Female

Single / Married

Live alone: Y / N

Have transportation: Y / N

CONTACT INFORMATION

Address

City | State | Zip Code

Phone | Phone 2 | Email

EMERGENCY CONTACT INFORMATION

First Name/Last Name | Relationship | Phone

WORK INFORMATION

Occupation | Employer | Work Phone

INSURANCE INFORMATION

Primary Insurance or Enter "Self Pay" | Member ID | Member Name | Member Birth Date

PRIMARY CARE PHYSICIAN

Physician/Practice Name | Phone | Date of Last Visit

REFERRING PHYSICIAN

Physician/Practice Name | Phone | Date of Last Visit

PATIENT/AUTHORIZED SIGNATURE | DATE

PATIENT/AUTHORIZED PRINTED NAME

HHSP ID#

REVIEWED:

A PATHWAY TO HEALING

PATIENT REGISTRATION PART 2

HISTORY

CURRENT MEDICATIONS

Medication	Dose	Medication	Dose

ALLERGIES

Allergy	Reaction	Date

PAST MEDICAL PROBLEMS

Problem	Date

SURGERIES

Surgery	Facility	Date

SOCIAL/FAMILY

Smoker? ☐ Never ☐ Yes ____ Packs per day for ____ Years ☐ Quit Year ____

Drinks? ☐ Never ☐ Yes ____ Drinks per day for ____ Years ☐ Quit Year ____

Recreational Drugs? ☐ Never ☐ Yes ☐ No

Mother Alive? ☐ Yes ☐ No Cause of death ____

Father Alive? ☐ Yes ☐ No Cause of death ____

Pertinent disease(s) that run in your family ____

Patient First Name ____ Patient Last Name ____ Date of Birth ____

PATIENT REGISTRATION PART 3

REVIEW OF SYSTEMS

CONSTITUTIONAL

Appetite Change	◯Y ◯N	Intended Weight Loss	◯Y ◯N	Pain	◯Y ◯N
Chills	◯Y ◯N	Lethargy	◯Y ◯N	Unintended Weight Gain	◯Y ◯N
Fever	◯Y ◯N	Fatigue/Tiredness or Malaise	◯Y ◯N	Unintended Weight Loss	◯Y ◯N
Insomnia/Difficulty Sleeping	◯Y ◯N	Night Sweats	◯Y ◯N	Weakness	◯Y ◯N
Intended Weight Gain	◯Y ◯N	Obesity	◯Y ◯N		

INTEGUMENTARY

Acne	◯Y ◯N	Ulcer	◯Y ◯N	Itching	◯Y ◯N
Contact Dermatitis	◯Y ◯N	Keloids	◯Y ◯N	Rashes	◯Y ◯N
Dryness	◯Y ◯N	Pigment Change	◯Y ◯N	Scars	◯Y ◯N

ALLERGIC/IMMUNOLOGIC

AIDS	◯Y ◯N	Lupus	◯Y ◯N	Lyme	◯Y ◯N
Collagen Vascular Disease	◯Y ◯N	Pyoderma Gangrenosums	◯Y ◯N	Scleroderma	◯Y ◯N
HIV	◯Y ◯N	Rheumatoid Arthritis	◯Y ◯N		

EYES

Blindness	◯Y ◯N	Cataract Removal	◯Y ◯N	Macular Degeneration	◯Y ◯N
Blurred Vision	◯Y ◯N	Contact Lenses	◯Y ◯N	Optic Neuritis	◯Y ◯N
Cataracts	◯Y ◯N	Glasses	◯Y ◯N	Retinal Detachment	◯Y ◯N

EARS, NOSE, MOUTH, THROAT

Chronic Sinusitis	◯Y ◯N	Eustachian Tube Problems	◯Y ◯N	Mid Ear Implants	◯Y ◯N
Dentures	◯Y ◯N	Hearing Loss	◯Y ◯N	Partial Dentures	◯Y ◯N
Difficulty Swallowing	◯Y ◯N	Herpes Simplex (Cold Sores)	◯Y ◯N	Sinus Surgery	◯Y ◯N
Cold Symtoms	◯Y ◯N	Meniere's Disease	◯Y ◯N	Upper Respiratory Infection (<6months)	◯Y ◯N

RESPIRATORY

Apnea	◯Y ◯N	Cold Symtoms	◯Y ◯N	Seasonal Allergies	◯Y ◯N
Asthma	◯Y ◯N	COPD	◯Y ◯N	Snoring	◯Y ◯N
Bloody Sputum	◯Y ◯N	Oxygen Dependence	◯Y ◯N	Shortness of breath	◯Y ◯N
Bronchitis	◯Y ◯N	Pulmonary Fibrosis	◯Y ◯N	Spontaneous Pneumothorax	◯Y ◯N
Chronic Cough	◯Y ◯N	Respiratory Infection	◯Y ◯N	Tuberculosis	◯Y ◯N

CARDIO

Angina (chest pain)	◯Y ◯N	Hypertension (high blood pressure)	◯Y ◯N	Pacemaker	◯Y ◯N
Arrhythmia (irregular heartbeat)	◯Y ◯N	Hypotension (low blood pressure)	◯Y ◯N	Palpitations	◯Y ◯N
Chest Pain	◯Y ◯N	Miocardial Infarction (MI-heart attack)	◯Y ◯N	PND (sit up to breath when sleeping)	◯Y ◯N
Congestive Heart Failure (CHF)	◯Y ◯N	Murmur	◯Y ◯N	Shortness of breath on exertion	◯Y ◯N
Defibrillator	◯Y ◯N	Orthopnea	◯Y ◯N		

VASCULAR

Arterial Surgery	◯Y ◯N	Leg Swelling	◯Y ◯N	Varicose Veins	◯Y ◯N
Claudication (pain on exercise/walking)	◯Y ◯N	Necrosis/Gangrene	◯Y ◯N	Vein Surgery	◯Y ◯N
DVT (blood clot in leg)	◯Y ◯N	Rest Pain	◯Y ◯N		

Reviewed by _____ Date _____

continued...

Patient First Name _____ Patient Last Name _____ Date of Birth _____

PATIENT REGISTRATION PART 4

HYPERBARIC HEALTH SERVICES Palatka

REVIEW OF SYSTEMS CONTINUED

GASTROINTESTINAL

Acid Reflux	Y N	Cirrhosis of liver	Y N	Liver disease	Y N
Anorexia	Y N	Constipation	Y N	Malnutrition	Y N
Ascites	Y N	Diarrhea	Y N	Vomiting	Y N
Blood in stool	Y N	Dysphagia (difficulty swallowing)	Y N	Nausea	Y N
Bowel Incontinence	Y N	Hepatitis	Y N	Obesity	Y N
Bulimia	Y N	Hiatal Hernia	Y N	Stomach Ulcers	Y N
Change in appetite	Y N	Jaundice	Y N	Colostomy (colon pouch)	Y N

GENITOURINARY

Chronic Renal Insufficiency	Y N	Foley Catheter	Y N	Nocturia	Y N
Cystostomy	Y N	Hemodialysis	Y N	Peritoneal Dialysis	Y N
Dysuria	Y N	Intermittent Catheter	Y N	Suprapubic Catheter	Y N
ESRD (renal failure)	Y N	Kidney Transplant	Y N	Urinary Frequency	Y N

MUSCULOSKELETAL

Alteration of Gait	Y N	Joint Stiffness	Y N	Painful Nails	Y N
Arthritis	Y N	Joint Swelling	Y N	Previous Fracture	Y N
Changes in feet	Y N	Muscle Waisting	Y N	Previous Amputation	Y N
Charcot	Y N	Myalgias (muscle pain)	Y N		

NEUROLOGICAL

Dizziness	Y N	Paraplegia	Y N	Stroke	Y N
Focal Headaches	Y N	Parkinson's Disease	Y N	Syncope (passing out)	Y N
Migraine	Y N	Quadriplegia	Y N	TIA (mini strokes)	Y N
Muscular Dystrophy	Y N	Seizures	Y N	Weakness	Y N
Neuropathy	Y N	Spinal Cord Injury	Y N		

ENDOCRINE

Addison Disease	Y N	Hyperglycemia (high blood sugar)	Y N	Hypothyroidism	Y N
Cushing's Disease	Y N	Hyperthyroidism	Y N	Thyroid Disease	Y N
Diabetes	Y N	Hypoglycemia (low blood sugar)	Y N		

LYMPHATIC/HEMATOLOGIC

Bleeding Disorder	Y N	Hypercoagulable (clotting disorder)	Y N		
Bruising	Y N	Lymphedema	Y N		

PSYCHIATRIC

Anxiety	Y N	Depression	Y N	Psychosis	Y N
Bipolar	Y N	Impaired Judgment	Y N	PTSD	Y N
Claustrophobia	Y N	Memory Loss	Y N		
Dementia/Alzheimer's	Y N	Panic Attacks	Y N		

continued...

Reviewed by Date

Patient First Name Patient Last Name Date of Birth

PATIENT REGISTRATION PART 4

REVIEW OF SYSTEMS CONTINUED

HYPERBARIC

Asthma	◯Y ◯N	Ear Surgery/Non-compliant TM	◯Y ◯N	Recent High Fever	◯Y ◯N
Cancer History	◯Y ◯N	Optic Neuritis	◯Y ◯N	Seizures	◯Y ◯N
Cataract Removal	◯Y ◯N	Previous Hyperbaric Treatment	◯Y ◯N	Spontaneous Pneumothorax	◯Y ◯N
Cataracts	◯Y ◯N	Recent Administration of:		Steroid Use	◯Y ◯N
Chronic Sinusitis	◯Y ◯N	Cisplatinum	◯Y ◯N	Thoracic Surgery	◯Y ◯N
Congenital Spherocytosis	◯Y ◯N	Adriamycin	◯Y ◯N	Implanted Device	◯Y ◯N
COPD	◯Y ◯N	Bleomycin	◯Y ◯N	Insulin Dependent	◯Y ◯N
Recent Upper Respiratory Infection	◯Y ◯N	Heart Disease	◯Y ◯N	Pregnancy	◯Y ◯N

REASON FOR REFERRAL(please include brief history and diagnosis)

CERTIFICATION

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

PATIENT/AUTHORIZED SIGNATURE DATE

PATIENT/AUTHORIZED PRINTED NAME AUTHORIZED RELATIONSHIP TO PATIENT

Patient/ Authorized Representative Address

City State Zip Code

Phone Phone 2 Email

Reviewed by Date

Patient First Name Patient Last Name Date of Birth

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Hyperbaric Health Services
Palatka
524 Zeagler Drive
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(386) 385-3857
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HyperbaricsPalatka@gmail.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name | Date of birth

I, _____ _____, authorize the use and disclosure of my protected health information as described below.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy or other medical caregiver that has treated me or provided medical services or supplies to me to disclose my protected health information to Hyperbaric Health Services.

The protected health information that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers.

I understand that Hyperbaric Health Services will use and disclose my protected health information for the following purposes: For treatment of my medical condition.

I understand that Hyperbaric Health Services will not condition my treatment on this authorization.

I understand that I may revoke this authorization at any time by sending a written notification addressed to: Hyperbaric Health Services 150 Southpark Blvd, St Augustine, Florida 32086, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that Hyperbaric Health Services already has used or disclosed.

This authorization expires 30 months from the date of signature.

PATIENT OR AUTHORIZED SIGNATURE

_____ _____

PATIENT/AUTHORIZED SIGNATURE DATE

_____ _____

PATIENT/AUTHORIZED PRINTED NAME AUTHORIZED RELATIONSHIP TO PATIENT

FINANCIAL RESPONSIBILITY

Hyperbaric Health Services
Palatka
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NOTICE OF FINANCIAL RESPONSIBILITY

We are pleased to have the opportunity to provide medical services to you. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to before any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- All procedures, visits, dressing changes, diagnostic test, and facility charges will be filed with your insurance company and may come from more than one collaborating entity.
- You will be financially liable for any balances deemed patient responsibility by your insurance company. This includes deductibles, coinsurance, and copays.
- It is your responsibility to know your own insurance coverage, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.
- We will check your eligibility with your insurer. We will obtain authorization for treatment from your insurance company when required. It will be your responsibility to maintain benefits throughout your treatment. Please be advised that even with pre-authorization, payment of benefits by your insurance company is not a guarantee. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Please understand some insurance coverage have Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

INSURANCE INFORMATION

Primary Insurance	Member ID	Member Name	Member Birth Date

Secondary Insurance	Member ID	Member Name	Member Birth Date

SELF PAY

Initials _____ I understand that my elective treatment is not covered by insurance and I accept full financial responsibility for my care.

CERTIFICATION

I have read the financial policies outlined above, and my signature below serves as an acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

PATIENT/AUTHORIZED SIGNATURE _____ DATE _____

PATIENT/AUTHORIZED PRINTED NAME _____ AUTHORIZED RELATIONSHIP TO PATIENT _____

COMMUNICATION

Hyperbaric Health Services
Palatka
524 Zeagler Drive
Palatka, Florida 32177
(386) 385-3857
fax (386) 530-2052
HyperbaricsPalatka@gmail.com

I _____ hereby request that the Practice make all communications to me by the alternative means that I have listed below:

HOME PHONE

Home number _____

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back numbers only

CELL PHONE

Cell number _____

- ☐ Ok to leave message or TEXT with detailed information
- ☐ Leave message with call back numbers only
- ☐ Leave TEXT message with call back numbers only

WORK PHONE

Work number _____

- ☐ Ok to leave message or TEXT with detailed information
- ☐ Leave message with call back numbers only
- ☐ NEVER CALL AT WORK

FAX PHONE

Fax number _____

- ☐ Ok to fax the number listed above

EMAIL

Email address _____

- ☐ Ok to email detailed information

ADDITIONAL INFORMATION RELEASE

I authorize this facility to release my information to the following individuals:

Name	Relationship	Phone			
			☐ Billing	☐ Appointments	☐ Medical
			☐ Billing	☐ Appointments	☐ Medical
			☐ Billing	☐ Appointments	☐ Medical

_____ _____

PATIENT/AUTHORIZED SIGNATURE DATE

_____ _____

PATIENT/AUTHORIZED PRINTED NAME AUTHORIZED RELATIONSHIP TO PATIENT

CONSENT TO TREAT

Hyperbaric Health Services
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HyperbaricsPalatka@gmail.com

CONSENT

I, _____, hereby grant consent to and authorize Hyperbaric Health Services, its physicians, staff, and agents to treat me with HYPERBARIC OXYGEN THERAPY for the condition of:

_____
Reason for treating with HBOT

I understand that hyperbaric oxygen therapy might call for more than one treatment and I hereby authorize the hyperbaric physicians to determine the number of treatments necessary to treat my condition.

Further, I understand that there are extremely rare risks associated with Hyperbaric Oxygen Therapy and the approach to mitigate these risks have been explained to me.

Risks associated with hyperbaric oxygen therapy:

1. Oxygen toxicity-central nervous system/lung (seizure/fits)
2. Ear drum discomfort/rupture; sinus pain; dental pain
3. Myopia, vision change (reversible after HBO)
4. Increased cataracts growth rate (thickening of lens/change in vision)
5. Increase risk of fire
6. Over pressurized lung; embolism; pneumothorax; emphysema (collapsed lung/bubbles in bloodstream)
7. If you are diabetic, your blood sugar may drop while in chamber
8. Pulmonary edema (lung fluid accumulation)

The nature and purpose of hyperbaric oxygen therapy has been explained to me by _____ and I hereby acknowledge that I know and understand the nature and the purpose of the treatments. Additionally, a practitioner has explained to me the consequences, risks and alternatives to receiving hyperbaric oxygen treatment.

I understand that, like other medical treatments, no two cases are exactly alike and results may very. While success rates are well demonstrated with hyperbaric oxygen therapy, no guarantee of outcome has been made with regards to my treating with hyperbaric oxygen therapy. I have been given the opportunity to ask questions and have them answered so that I can form my own decision with regards to my treatment.

I agree to hold harmless and release from any liability the healthcare provider, facility, and their respective agents, employees, and affiliates for any injury, harm, or damages that may occur as a result of the hyperbaric oxygen therapy.

_____ _____
PATIENT/AUTHORIZED SIGNATURE DATE

_____ _____
PATIENT/AUTHORIZED PRINTED NAME AUTHORIZED RELATIONSHIP TO PATIENT

HYPERBARIC SAFETY

Hyperbaric Health Services
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PROHIBITED ITEMS

As a reminder, the following items are PROHIBITED in the Hyperbaric Chamber:

Reading material (newspaper, magazines, books, etc.)
Drinks, snacks, candy, gum or food of any kind (water will be available for you to take in the chamber)

Please do not wear any of the following:

Makeup, lipstick, lip balm, or base, deodorant (we will have you remove them)
Hairspray, Gel, Mousse, fresh Coloring, fresh Perms, wigs, hair extensions, hair rubber bands
Vaseline, Oils, Lotions of any kind, any Petroleum based products, any Alcohol based products.
Thermal Wrap or patches, Hand Warmers, or any Heat producing products.
No nail polish or nail extensions
Velcro
Prosthetics

Electronic Devices such as: (may be placed in a locker at the clinic)

Watches, cell phones, pagers, PDA's.
External pace makers, internal pace makers prior to 1980
Hearing aids
Insulin pumps
Handheld video games, computers, cameras
Lasers, pen lights

Other items that should not be brought in to hyperbaric chamber include:

Matches or lighters
Medication patches – Please inform the staff prior to entering the hyperbaric chamber
Tobacco products of any kind (cigarettes, cigars, chew, snuff, pipes)
Jewelry of any kind (please leave them at home or with a spouse)

Anything deemed unsafe by the staff at Hyperbaric Health Services will be prohibited. Please know we put safety above all else.

CANCELLATION/MISSED APPOINTMENT

PLEASE GIVE US A COURTESY CALL AT (386) 385-3857 IF YOU WILL BE LATE OR IF YOU ARE NOT GOING TO BE IN FOR YOUR APPOINTMENT.

Thank you again for choosing Hyperbaric Health Services. If there is anything that you need while treating with us, please do not be afraid to ask any of the staff members for help.

PATIENT/AUTHORIZED SIGNATURE | DATE

PATIENT/AUTHORIZED PRINTED NAME | AUTHORIZED RELATIONSHIP TO PATIENT