Sooner OXYGEN THERAPY

Thank you for selecting our hyperbaric team! We will strive to provide you with the best possible service. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information

CONTINUE ONLY IF:

Not currently prescribed or taking medications:
Bleomycin, Disulfiram, Mafernide Acetate

Do not have or suspect having:
Hereditary Sperocytosis, Sickle Cell Anemia, COPD

Date: _____

Name: _____

Address: _____ *Birth Date:* _____

City: _____ *State:* _____ *Zip Code:* _____

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____

Email Address: _____

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Minor, Parent or Legal Guardian: _____

Spouse's Name: _____

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____

Person to Contact in Case of Emergency: _____ *Phone:* _____

What Is Your Primary Reason for Coming to Hyperbaric PHP?

_____

_____

_____

_____

Who May We Thank for Referring You? _____

Physician Information

Are You Currently Under a Doctor's Care? ☐*Yes* ☐*No*

Physician's Name: _____

Address: _____

City: _____ *State:* _____ *Zip Code:*

Phone: _____ *Fax:* _____

Patient Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Do you exercise on a regular basis?	☐	☐
If so, how often? _____		
3. Do you use tobacco?	☐	☐
4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain.		

	Yes	No
5. Do you use alcohol?	☐	☐
If so, how often? _____		
6. Are you pregnant or think you may be pregnant?	☐	☐
If so, how many weeks? _____		
If no, what was the date of your last menstrual period? _____		
7. Are you taking any medication(s)?	☐	☐
If yes, what medication(s) are you taking?		

8. List any medications you are allergic to: _____

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Acute Respiratory Illness	☐	☐	Frequent Ear Infections	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	Neurological Disease	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation Therapy	☐	☐
Angina	☐	☐	Hay Fever/Allergies	☐	☐	If YES, When? _____		
Anxiety	☐	☐	Hepatitis/Jaundice	☐	☐	Recent Weight Loss	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Back Pain	☐	☐	Heart Murmur	☐	☐	Ringing in the Ears	☐	☐
Cancer	☐	☐	Heart Problems	☐	☐	Rosacea	☐	☐
Chemical Sensitivity	☐	☐	Herpes	☐	☐	Seizure Disorders	☐	☐
Chest Pains	☐	☐	High Blood Pressure	☐	☐	Stomach Problems/Ulcers	☐	☐
Chronic Bronchitis	☐	☐	Infections, Frequent	☐	☐	Stroke	☐	☐
Chronic Fatigue (CFS)	☐	☐	Kidney Disease	☐	☐	Swollen Ankles	☐	☐
Claustrophobia	☐	☐	Leukemia	☐	☐	Thyroid Problems	☐	☐
Diabetes – Insulin Dependant	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Other:	☐	☐
Fainting / Seizures	☐	☐	Lung Disease	☐	☐	_____	☐	☐
Fever Related Seizures	☐	☐	Lung Infection, Frequent	☐	☐	_____	☐	☐
Fibromyalgia	☐	☐	Malignant Disease	☐	☐	_____	☐	☐

	Yes	No
10. Have you ever had any ear problems?	☐	☐
11. Do you have any problems with your ears when you fly?	☐	☐
12. Do you have any problems going up and down in an elevator?	☐	☐
13. Do you have back problems?	☐	☐

Patient Comments:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment. I understand it is my responsibility to update this information as needed. This includes changes in medical conditions / diagnosis, medications and personal and physician contact information. I agree to be responsible for payment of all services rendered on my or my dependents behalf.

Signature of patient (parent or guardian) _____

Doctor's Comments: Date: _____

mild Hyperbaric Therapy Consent Form

The technology, known as mild Hyperbaric Therapy (mHBT), has been reported to have beneficial effects for a wide range of conditions, without negative side effects. Nevertheless, as with many treatments, there are areas of concern which you should be aware. It is important that you take a few minutes to read the following information.

OTIC BAROTRAUMA*: Is a condition of injury to the eardrum, and is extremely unlikely to occur in the mild hyperbaric chamber. However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized and depressurized you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You will most likely experience "popping" in your ears. This is normal. You can assist the equalization process by yawning, chewing, swallowing, working your jaw side to side and up and down, turning the head side to side and ear to shoulder. Sitting upright in the chamber during pressurization and depressurization will generally also make the equalization process more comfortable. In general, doing whatever assists you being comfortable when taking off and landing in a plane may be most effective for you. Continue to do this as needed for the duration of pressurization and depressurization. When the chamber reaches full pressure and again when the chamber is completely deflated there should be no additional pressure in the ears****. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF.*** *This will give us the opportunity to make adjustments in the pressurization or depressurization process to eliminate discomfort. If you are unable to equalize the pressure in your ears the visit will be immediately terminated. If this happens or if pain persists beyond the visit, we recommend that you consult your physician to evaluate and alleviate the situation before attempting another visit.*

EAR, SINUS AND/OR THROAT CONGESTION, HEAD COLDS, VIRUS OR PRIOR TRAUMA TO THE EARS*: You may consider rescheduling your visit in the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent but may occur****. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF*** *so we can assist you or terminate your visit****.*** *We recommend you consult your physician in order to alleviate the underlying condition before attempting another visit.*

PULMONARY HYPEREXPANSION*: This condition is very rare under mild hyperbaric treatments. However, to be overly cautious,* ***HOLDING YOUR BREATH DURING DECOMPRESSION MUST BE AVOIDED*** *as it could lead to expansion of the air in your lungs and damage to the lung tissues. In the highly unlikely event of an unexpected rapid decompression, it is critical that you exhale immediately.*

MEDICATIONS*: mild Hyperbaric Therapy may enhance the effectiveness or increase the metabolism (decrease the effectiveness) of any medication you are taking.* ***IT IS RECOMMENDED THAT YOU HAVE THE DOSAGE AND FREQUENCY OF ALL MEDICATIONS MONITORED AND ADJUSTED REGULARLY BY YOUR PHYSICIAN****.*

PREGNANCY*:* ***MILD HYPERBARIC THERAPY IS NOT ALLOWED DURING THE FIRST TRIMESTER.*** *After this time it may be beneficial to both mother and child.*

INITIALS _____

***SEIZURES**: mild Hyperbaric Therapy is not associated with causing or inducing seizures. To be on the cautious side we have established a seizure protocol that involved reaching full pressure (4.2psi) and spending full treatment time (standard 1 hour) in the chamber over a series of staged visits**. IF ANYONE IN GETTING IN THE CHAMBER IS SEIZURE PRONE, THE STAFF MUST BE MADE AWARE PRIOR TO THE FIRST VISIT.** If a seizure is experienced in our clinic, unless otherwise instructed (and a waver is signed), our procedure is to call 911, remove the patient from the chamber and make the individual as comfortable as possible.*

***DETOXIFYING OR CELL DIEOFF**: mild Hyperbaric Therapy may assist the body to naturally detoxify and balance digestive flora. **AN INDIVIDUAL MAY EXPERIENCE SOME DISCOMFORT FROM THIS PROCESS IN AS LITTLE AS 1 TO 36 HOURS AFTER TREATMENT**. Symptoms may include; flu like symptoms, loss of appetite, stomach ach, constipation, diarrhea, headache, behavioral issues etc. Although unpleasant, this is a natural process and continuing treatments may be of benefit to more rapidly accomplish a positive result. However **IF SYMPTOMS PERSIST, WE RECOMMEND CONSULTING YOUR PHYSICIAN TO EVALUATE AND ALLEVIATE THE SITUATION BEFORE ATTEMPTING ANOTHER VISIT**.*

***PNEUMOTHORAX**: mild Hyperbaric Therapy is contraindicated for an existing pneumothorax (collapsed lung). **IF YOU HAVE A PNEUMOTHORAX OR SUSPECT THAT A PNEUMOTHORAX IS AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.** If you have experienced a pneumothorax in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy you should be able to proceed with mild Hyperbaric Therapy.*

***COMPRESSIVE BRAIN LESIONS – SUBDURAL HEMATOMA, INTERCRANIAL HEMATOMA**: mild Hyperbaric Therapy is contraindicated for existing compressive brain lesions (subdural hematoma, intercranial hematoma). **IF YOU HAVE COMPRESSIVE BRAIN LESIONS OR SUSPECT THAT COMPRESSIVE BRAIN LESIONS ARE AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.** If you have experienced compressive brain lesions in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy.*

***DIABETES / INSULIN DEPENDANT**: Insulin dependency may result in a drop in blood sugar while in the chamber. **IT IS CRITICAL THAT YOU IMMEDIATELY COMMUNICATE TO THE STAFF IF YOU EXPERIENCE OR ANTICIPATE AN EPISODE. YOUR TREATMENT WILL BE TERMINATED.** You are required to; A) take a blood sugar reading prior to your treatment (if below 150, you must have a snack prior to treatment) and again after your treatment (if below 150, you must have a snack prior to leaving). B) Take a protein bar and a juice box (or whatever you use if faced with a "drop" in the normal management of your condition) into the chamber with you.*

***SENSITIVITY TO CHEMICALS (MCS) / ODORS / ALLERGY**: Avoid wearing heavy colognes as the smells may linger in the chamber and have an adverse effect on another patient**. IF YOU EXPERIENCE ADVERSE SENSITIVITY OR HAVE ALLERGIES THAT MAY BECOME AGGRAVATED WHILE IN THE CHAMBER, LET THE STAFF KNOW PRIOR TO YOU VISIT OR AS SOON AS POSSIBLE WHEN IN THE CHAMBER SO MEASURES CAN BE TAKEN TO ASSURE YOUR COMFORT OR IF YOUR VISIT NEEDS TO BE TERMINATED.** We recommend that you wearing a charcoal mask or filter if it is known to assist your condition. If these sensitivities persist and you cannot exist comfortably in the chamber, you will need to consult your physician in order to alleviate the underlying condition before attempting another visit.*

I have read and fully understand the above information.

Signature _____ Date: _____/_____/_____

PRIVATE LICENSE

The undersigned hereby grants a Private License to Sooner Oxygen Therapy to provide mild hyperbaric therapy to the undersigned. The undersigned acknowledges that Sooner Oxygen Therapy and its agents do not diagnose neither prescribe for medical or psychological conditions nor claim to prevent, treat, nor cure any condition. Its agents do not provide diagnosis, care, treatment or rehabilitation of individuals, nor does Sooner Oxygen Therapy or its agents apply medical, mental health or human development principles, but rather provides mild hyperbaric therapy technology that may benefit.

The undersigned acknowledges giving Informed Consent to the services that will be provided.

The undersigned hereby releases Sooner Oxygen Therapy and its agents from all claims and liabilities arising from the use or misuse of hyperbaric therapy indemnifying and holding Institute and its agents harmless from all claims and liabilities wherefrom, whatsoever. The Institute and its agents reserve all rights.

In the unlikely event that the client has a dispute with Sooner Oxygen Therapy, the client agrees that the dispute shall be settled by arbitration through the Better Business Bureau of Oklahoma City.

I (print name)_____ have read, fully understand and consent to treatments in the mild hyperbaric chamber. I have also completed the health questionnaire which accompanies this consent form, and I agree to hold Sooner Oxygen Therapy harmless from blame regarding hyperbaric therapy services provided by Sooner Oxygen Therapy.

Although mild hyperbaric therapy has been reported to be beneficial for a wide range of conditions, this therapy is not meant as a cure for any condition or disease and no therapeutic outcomes can be guaranteed. We do not in any way recommend hyperbaric therapy as a substitute for any medical treatments prescribed or suggested by any medical physician. We do not make any guarantees to any results that an individual may experience. We are NOT medical practitioners. We do not accept insurance for our services.

Signature _____ **Date:** _____/_____/_____

HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES SOONER OXYGEN THERAPY TO USE AND / OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- **I give permission to Sooner Oxygen Therapy to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related information, about treatment alternative, or other health related information.**

  Initial _____

- **I give permission to Sooner Oxygen Therapy to leave a phone message on my answering machine or voice mail.**

  Initial _____

- **I give Sooner Oxygen Therapy permission to provide hyperbaric therapy in an open room where other patients are also receiving hyperbaric therapy. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.**

  Initial _____

Signature _____ Date: ____/____/_____

PROMOTION AND DOCUMENTATION AUTHORIZATION FORM

Patient: _____ Parent or Legal Guardian: _____

To assist in the promotion and documentation of our services here at the center, we request permission to photograph you and/or your child. This photograph may be used, along with your name and testimonial, in printed form on display in our center, in printed form on display during promotional events around the country, in digital form on educational CDs or on our website.

SPECIFIC AUTHORIZATIONS

- **I give** Sooner Oxygen Therapy **permission to use my photograph or my child's photograph in printed form on display at the center or during promotional events.**

  Initial _____

- **I give** Sooner Oxygen Therapy **permission to use my name and/or my child's name in printed form on display at the center or during promotional events.**

  First names only Initial _____

  Both first and last name Initial _____

- **I give** Sooner Oxygen Therapy **permission to use all or part of my testimonial in printed form on display at the center or during promotional events.**

  Initial _____

- **I give** Sooner Oxygen Therapy **permission to use my testimonial in digital form on a promotional / educational CD or on our website.**

  Initial _____

By signing this form you are giving Sooner Oxygen Therapy permission to use and disclose your protected health information in accordance with the directive listed above.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Sooner Oxygen Therapy will not refuse to provide treatment.

You have the right to revoke this AUTHORIZATION at any time. Details will be provided upon your request.

Signature _____ Date: ____/____/_____

Informed Consent

For Nutritional Consultation

Health By Daniel LLC, Danny Wood II QRA

Advanced Nutritional Programs

I acknowledge that Danny Wood II and his staff members are not medical doctors. I understand that Danny Wood II and his staff members provide nutritional and other health-related information to help me attain and maintain my best health. Danny Wood II will help determine which nutrients my body needs bolstered. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits and advanced nutrition. I understand that Danny Wood II and his staff members do NOT diagnose, treat, cure or claim to cure cancer or any other disease.

Consultation Fees

The consultation fee for Danny Wood II is $60.00 per hour (based upon 55 minutes per hour), prorated for the actual time spent with the client. The initial visit typically takes about 2 hours which includes a thorough review of present nutritional concerns and an advanced, comprehensive nutritional program including recommended state-of-the-art nutritional supplements. Nutritional testing will be performed to pinpoint-target special body needs. In addition, QRA^{SM} Kinesiological testing may be used to help identify specific needs and interference fields. Follow-up appointments are usually recommended at 4-8 week intervals and average 60 minutes or less per session, depending on the extent of each client's needs and concerns. In special cases, weekly appointments may be recommended.

Nutritional Supplement Purchases: I understand that the cost of nutritional supplements is separate from consultation fees.

Returned Checks: If paying by check, I understand that an additional $30.00 processing fee will be assessed for each returned check or "stop payment" check.

Scheduling Policy

I understand that Danny Wood II's Office will call me 24 hours prior to my appointment to confirm. I understand that if I want to reschedule or cancel my appointment for any reason, it is my responsibility to call his office during business hours, 5 business days or more in advance of my scheduled appointment. I understand that if I fail to reschedule or cancel my appointment at least 5 business days in advance of my scheduled appointment, there is a $60.00 non-refundable processing fee. I understand that leaving a voicemail or sending an e-mail message to reschedule or cancel my appointment is not acceptable.

"Essentials Only" Program

I understand I may request an "Essentials Only" Nutritional Program with an abbreviated consultation time, such as 30 minutes. This program will provide essential nutritional recommendations, including recommended nutritional supplements. The fee for this program is the same as above ($60.00 per hour), but prorated for the actual time spent. If I wish to have an "Essentials Only" Program, I understand I need to indicate this when I schedule my appointment.

Informed Consent

For Nutritional Consultation

Health By Daniel LLC, Danny Wood II QRA

Time Allotment

I understand it is my responsibility to observe the length of time my consultation is taking. Although Danny Wood II is glad to answer questions as the consultation proceeds, it naturally extends the length of the consultation time. I understand that if I do not wish to go beyond a certain time limit, I need to inform Danny Wood II before the consultation begins.

Interruptions

Due to the busy nature of Danny Wood II's office, I understand there may be occasional interruptions during my consultation time. If this happens, the number of minutes of the interruption will be deducted from my total time. Danny Wood II and his staff apologize for any inconvenience.

Follow-Up

I understand that any questions I may have should be asked during my consultation time. If I have questions after the consultation, I understand that I should schedule a telephone consultation with Danny Wood II. (See below.)

Telephone Consultation and Emergencies

I understand that if I have any questions between scheduled visits, or if an emergency arises, or if I would just like to speak personally to Danny Wood II, I will need to call to schedule a 15 minute consultation time (or longer). Danny Wood II will then answer my questions during this brief consultation time. Consultation fees are calculated at $15.00 per 15 minutes.

Nutritional Supplement Policy

I understand that while I am under the care of Danny Wood II, I agree to purchase my nutritional supplements and place my orders through him or his assistant rather than Healthline for a period of six months. This helps to assure that my nutritional program will proceed smoothly.

Consent. I have read this Informed Consent and understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state or local agencies on a mission of entrapment or investigation and I also certify that I am signing my own true given, legal name and not an alias or a pseudo or false name.

Signature_____

Printed Name_____

Witness_____

Date_____

Date_____