North Florida Amputation Prevention Center - Hyperbarics
2140 Kingsley Avenue, Suite 9, Orange Park, FL 32073
904 375 2070 ▪ facsimile 904 375 2075

Patient Information (COMPLETE AND RETURN COPY VIA EMAIL TO: INFO@NORTHFLORIDAHYPERBARICS.COM)

Name _____ SSN #_____

Address _____ Marital Status M S D W Gender M F

_____ Birth Date _____ / _____ / _____ Age _____

Phone _____ Cell _____ Other _____

Occupation _____ ☐ Retired e-mail _____

Employer _____ Phone_____

Employer Address _____

Emergency Contact _____ Relationship _____

Day Phone _____ Evening Phone _____ Other _____

Physician Information

Are you currently under a doctor's care? ☐ Yes ☐ No

Referring Physician's Name/Specialty _____

Address _____

Phone _____ Facsimile _____

Other Physicians **(indicate Primary Physician ☑:**

Name/Specialty ☐ _____ Phone _____

Name/Specialty ☐ _____ Phone _____

Medical History

CHRONIC ILLNESS	PATIENT YES	PATIENT NO	FAMILY YES	FAMILY NO	EXPLAIN (Who, Age)
Acute Infections					
Arthritis/Gout					
Bleeding					
Cancer					
Convulsions/Seizures					
Diabetes					
Heart Trouble					
Hereditary History					
Hypertension					
Stroke					
Other Patient History					
Other Family History					

Allergies (Please list all known allergies)

_____

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Prior to Therapy - Mandatory Medical Clearance Requirements

Based on the information received, additional information or testing may be required PRIOR to your first session.

Medical Records from ALL physicians seen in the last ninety (90) days
Blood work / Lab Tests - including CBC, A1C (within the last 60 days)
EKG Report (within the last 60 days)
Chest X-Ray (If medical records do NOT include chest x-ray results with 60 days, one will be required).
Radiology Results (i.e. MRI, PET, CT, etc.) (within the last 60 days)

Medications (list *all* medicines you are currently taking. Please use separate sheet, if necessary.

Medication	Amount/Frequency	Reason (Blood Pressure, etc.)	Prescribing Physician

Are you taking any of the following medications now or recently? If yes, please check
☐ Bleomycin ☐ Disulfiram/Antabuse ☐ Doxorubicin/Adriamycin ☐ Mafernide Acetate ☐ Platinum/Cisplatin

Hospitalizations/Surgical History (list all past hospitalizations)

Name of Hospital	Purpose of Hospitalization	Date

Wound History (complete this section *only if you have a chronic wound or ulcer*)

Wound Location _____

How did your wound start? _____

Is your wound open and/or draining? _____

When did you first notice the wound? _____

How have you been treating your wound until now? _____

_____

Have you had any tests for circulation on your legs? ☐ No ☐ Yes (details _____)

Please indicate other problems, if any, associated with your wound ☐ INFECTION ☐ SWELLING ☐ PAIN

Other _____

_____

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Social History

Tobacco Use ☐ Never ☐ Previously, but quit ☐ Current packs/day _____

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Drug Use ☐ Never ☐ Type/Frequency _____

Caffeine Use ☐ Never ☐ Type/Frequency _____

System Review - Do you now have or *have you ever* had any of the following?

☐ Acute Respiratory Illness	☐ Frequent Ear Infections	☐ Memory Loss/Confusion
☐ AIDS or HIV Infection	☐ Frequent Urination	☐ Neurological Disease
☐ Anemia	☐ Glaucoma/Cataracts	☐ Pneumonia
☐ Angina	☐ Hay Fever/Allergies	☐ Pneumothorax
☐ Anxiety	☐ Hepatitis/Jaundice	☐ Pregnant
☐ Arthritis	☐ Heart Attack	☐ Prosthesis
☐ Asthma	☐ Heart Murmurs	☐ Recent Weight Loss
☐ Back Pain	☐ Hearing Loss	☐ Rheumatic Fever
☐ Colostomy	☐ Headaches/Migraines	☐ Ringing in ears
☐ Chest Pain	☐ High Temperature/Fever	☐ Rosacea
☐ Chronic Bronchitis	☐ Infections, (frequent)	☐ Shortness of breath
☐ Chronic Fatigue (CFS)	☐ Kidney Disease/Failure	☐ Sinus problems
☐ Claustrophobia	☐ Leukemia	☐ Stomach Problems/Ulcers
☐ Colostomy/Ileostomy	☐ Liver Disease	☐ Swollen ankles/feet
☐ Emphysema	☐ Low Blood Pressure	☐ Thyroid disease
☐ Excessive Thirst	☐ Lung Disease	☐ Tuberculosis
☐ Fainting	☐ Mitral Valve Prolapse	☐ Vision difficulties

Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold North Florida Amputation Prevention Center, the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to keep this information current, which includes changes in medical conditions and diagnosis, medications and personal and physician contact information.

_____ ___ / ___ / ___
Signature *Date*

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Insurance

PLEASE PROVIDE COPIES OF IDENTIFICATION AND ALL INSURANCE CARDS

Patient _____ SSN _____

Financial Responsibility _____ SSN _____

Primary Insurance _____ ID# _____

Other Insurance _____ ID# _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company/companies, and assign directly to this Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions. Secondary insurances are billed as a courtesy only.

_____ _____ ____ / ____ / ____
Responsible Party Signature *Relationship* *Date*

Medicare Authorization (Medicare Beneficiaries ONLY)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Center for any services furnished me. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to the pay the claim. If "other health insurance" is indicated on any approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. Secondary insurances are billed as a courtesy only.

_____ ____ / ____ / ____
Beneficiary Signature *Date*

Patient Authorization

We will file with your insurance company / companies. We ask that you DO NOT FILE, but that you supply this office with the necessary forms or information needed to file your claim for services rendered to you. If we cannot get coverage from your insurance, you will need to pay on a *self-pay* basis. Should questions arise on insurance matters please advise the Center.

With every insurance company, advance authorization, pre-determination, notice or approval is not a guarantee of payment, only the receipt of their check is guarantee of payment. *Should your insurance not cover these services, you will be responsible for payment.* When payment begins, they have accepted the claim. _____ Patient Initials

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Authorization To Disclose Health Information & Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ Phone No.: _____

The type and amount of information to be disclosed is as needed for HBOT treatment. I understand that the medical record may include information relating to sexually transmitted diseases, AIDS, HIV, behavioral or mental services, and treatment for alcohol and drug abuse. The records may be disclosed to and used by the Center. I understand that I have the right to inspect and obtain a copy of the information to be disclosed. The cost of copying and releasing the medical records, if any, conforms to State of Florida limits. Any revocation must be sent to the Center. This authorization does not expire unless written notification is received. This authorization to disclose health information is voluntary.

_____ _____ ____ / ____ / ____
Signature *Patient or Caregiver (Relationship)* *Date*

I understand it is my responsibility to advise the Center of any changes in my address, phone number, insurance coverage, or employment.

I, _____, hereby authorize the Center to apply for benefits on my
Patient Name
behalf for covered services rendered. I request payment be made directly to the Center.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or by the above named carrier at any time.

_____ _____ ___ / ___ / ___
Signature *Patient, Subscriber, or Beneficiary* *Date*

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations; I understand you are not required to agree to my requested restrictions.

Patient Name _____

_____ _____ ____ / ____ / ____
Signature *Patient or Caregiver (Relationship)* *Date*

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

_____ _____ ____ / ____ / ____
Signature *Reason* *Date*

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Patient Treatment Consent Form

Name of Patient _____ Date of Birth _____

I authorize the performance of a procedure known as Hyperbaric Oxygen Therapy to be performed under the direction of the Center.

As a patient, I give my consent to receive treatment of Hyperbaric Oxygen Therapy and have been informed of the benefits from Hyperbaric Oxygen Therapy and any possible side effects including but not limited to ear pain, sinus headache, breathing difficulty or chest pain. I will advise the Center *immediately* of any side effects or other oxygen treatments I am receiving at any other facility.

I have disclosed any and all current health issues and will advise the Center of any and all changes.

I acknowledge that the nature of this procedure has been described to me in terms which I understand and all questions I have asked have been answered to my satisfaction. *Any complications or risks which may be associated with this procedure or possible alternatives have been explained.*

I am aware that the practice of Hyperbaric Oxygen Therapy is not an exact science and that it promises no cures. I acknowledge that no guarantees have been made to me concerning the results of examination or treatments from this therapy.

_____ _____ _____
Signature of Patient or Representative Staff Witness Date

If the patient is unable to sign or is a minor, complete the following:

Patient is a minor (_____ years of age), and / or is unable to sign because

_____

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Patient Pre-Dive Checklist

IF YOU ARE SUFFERING FROM SYMPTOMS OF A COLD OR FLU-LIKE CONDITIONS, CALL OUR OFFICE IMMEDIATELY.

Wound Dressings must be approved by the technician.

Shampoo hair, do not use conditioner, shower off all lotions, make-up, powder, deodorant.
No nail polish, hair clips, wigs/hair pieces, hearing aids, contact lenses.
Advise technician if you wear dentures.

Wear 100% cotton clothing - *no Velcro* (including on underwear and/or diapers).

Depends®, cloth diapers and tampons are permitted (advise technician).

Ladies may wear 'sports bras' – no underwire bras.

No metal of any kind - including eye glasses, jewelry, watches, rings, etc.

Patients should take regular medications, including insulin. -- NO MEDICINAL PATCHES.
We suggest that you take Vitamin E (400 i.u.) during your hyperbaric therapy treatments.

Patients should not have carbonated drinks, alcohol, caffeine, or foods causing flatulence (such as beans) 24 hours prior to dive, as they can cause discomfort and/or interfere with treatment.

No food or drinks allowed in the chamber except as provided by the Center, which will be supplied in an acceptable container.

Hand warmers, chemical heat pads, nicotine or other patches, cigarettes and lighters are strictly prohibited, due to flammability.

No books. No Electronic equipment. No toys. NOTHING ELSE!

Patients are required to stop smoking before treatment, as smoking interferes with the body's ability to absorb oxygen. HBOT will assist in removing the chemical toxins from smoking that accumulate in the body.

DIABETICS: During a treatment, blood sugar may drop as much as fifty (50) points. It is important that you eat prior to your scheduled visit. **Please advise our technician of your blood sugar/glucose level prior to treatment. You MUST bring your blood glucose meter with you to EVERY appointment.**

I have read and agree to abide by this checklist for the safety of myself and the Clinic.

_____	_____	____ / ____ / ____
Signature of Patient or Representative	Staff Witness	Date

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Pre-payment Refund Policy - Cash Patient Only

In case the patient is unable to finish the desired and/or the anticipated Hyperbaric Oxygen Therapy Sessions *for any reason*, or has no desire to continue treatments, a maximum of $500.00 will be deducted from the pre-payment. The remaining balance, if any, will be refunded by company check payable to the payment source.

Appointment Hours & Scheduling Policy

Although we try to adapt to your schedule, appointments are scheduled on a **first-come basis**. We are open 7 days a week with *hours by appointment ONLY*, and are able to schedule up to thirty (30) days in advance. We regret that we cannot accommodate walk-ins. Due to changes or cancellations in the schedule, we may contact you to reschedule your appointment.

Appointment Cancellation Policy

We require **48 hours** notice to cancel appointments without charge. Appointments canceled with less than 48 hours notice will be charged $100.00 which covers time, equipment and staff. This fee may be waved at the discretion of the Center on a case-by-case, day-by-day basis. This fee is NOT covered by any insurance policy, and must be paid prior to additional treatments.

I have read and understand that there are no exceptions to the above policies, and agree to these terms.

_____	_____	____ / ____ / ____
Signature of Patient or Representative	Staff Witness	Date