

# Patient Information

Name: \_\_\_\_\_

Parent (minor) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Other needed information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: MSDW Spouse: \_\_\_\_\_

\_\_\_\_\_ Gender: M F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Month Day Year

Circle preferred number: Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Eve: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address: \_\_\_\_\_

**Physician Information**

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

Referring Physician's Name/Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax #: \_\_\_\_\_

Other Physicians:

Name/Specialty: \_\_\_\_\_ Phone # \_\_\_\_\_

Name/Specialty: \_\_\_\_\_ Phone # \_\_\_\_\_

Name/Specialty: \_\_\_\_\_ Phone # \_\_\_\_\_

**Medical History**

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

**Allergies** (Please list all known allergies)

\_\_\_\_\_

\_\_\_\_\_

**ORLANDO HYPERBARICS**  
 6200 Lee Vista Blvd, Ste 250, Orlando, Florida 32822  
 407-240-3996 [www.orlandohyperbarics.com](http://www.orlandohyperbarics.com) Fax: 407-264-6955

**Medications** (Please list all medicines you are currently taking)

Medication	Amount	How Often

Are you taking any of the following medications now or recently? If yes, please circle

*Bleomycin, Disulfiram/Antabuse, Doxorubicin/Adriamycin, Mafernade Acetate, Platinum/Cisplatin*

**Hospitalizations/Surgical History** (Please list all past hospitalizations)

Name of Hospital	Purpose of Hospitalization	Date

**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 \_\_\_\_\_

**Activities Of Daily Living** (Please check one for each item)

- |                            |  |   |                                   |
|----------------------------|--|---|-----------------------------------|
| <b>Care for Appearance</b> | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Use Toilet</b>          | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Bath/Shower</b>         | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Dress Self</b>          | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Feed Self</b>           | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Walk</b>                | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Get in/out of Bed</b>   | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Housework</b>           | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Prepare Meals</b>       | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Handle Money</b>        | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Take Medications</b>    | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Shop for Self</b>       | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| <b>Use Telephone</b>       | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |

**System Review**

**Do you or have you had any of the following?**

	Yes	No		Yes	No		Yes	No
Acute Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss/Confusion	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Temperature/Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Infections, (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue (CFS)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Colostomy/Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Vision difficulties	<input type="checkbox"/>	<input type="checkbox"/>

**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? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_

Please circle other problems associated with your wound- INFECTION SWELLING PAIN OTHER \_\_\_\_\_

**Signatures**

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of this form. I understand that it is my responsibility to update this information as needed. This includes changes in medical conditions/diagnosis, medications and personal and physician contact information.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ORLANDO HYPERBARICS**

6200 Lee Vista Boulevard, Suite 250, Orlando, Florida 32822  
407-240-3996 [www.orlandohyperbarics.com](http://www.orlandohyperbarics.com) Fax 407 264 6955

**Authorization to Disclose Health Information & Medical Records**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

I authorize \_\_\_\_\_ to release the above-named individual's  
Doctor's Name  
health information. The type and amount of information to be disclosed is as follows:

Doctor's phone # \_\_\_\_\_ FAX \_\_\_\_\_

\_\_\_\_\_ entire record \_\_\_\_\_ entire record in past year

\_\_\_\_\_ immunization records (all)

\_\_\_\_\_ laboratory results from (date) \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ x-ray and imaging reports from (date) \_\_\_\_\_ to \_\_\_\_\_

NPI # for doctor \_\_\_\_\_

I understand that the medical record may include information relating to sexually transmitted disease, AIDS, HIV, behavioral or mental health services, and treatment for alcohol and drug abuse. The records may be disclosed to and used by ORLANDO HYPERBARICS 6200 Lee Vista Blvd, Ste 250, Orlando, Fl 32822 Phone: 407.240.3996 Fax 407.264.6955. I understand that I have the right to inspect and obtain copy of the information to be disclosed. The cost of copying and releasing the medical records, if any, has been explained to me. I understand that I have the right to revoke this authorization in writing at any time. Any revocation should be sent to Advanced Hyperbarics at the address noted above. Unless revoked, this authorization will expire on the following date or condition \_\_\_\_\_.

Otherwise, this authorization will expire in one year. I understand that the revocation will not apply to any information that has been released as a result of this authorization. The authorization to disclose health information is voluntary. I am aware that this information is subject to disclosure by the recipient and may no longer be protected by the Privacy rule.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

**ORLANDO HYPERBARICS**

6200 Lee Vista Blvd, Ste 250, Orlando, Florida 32822  
407-240-3996 [www.orlandohyperbarics.com](http://www.orlandohyperbarics.com) Fax: 407-264-6955

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & MEDICAL RECORDS**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_

I authorize \_\_\_\_\_ to release the above named individual's health information.

**DOCTOR'S NAME**

The type and amount of information to be disclosed is as needed for HBOT treatment:

Doctor's phone # \_\_\_\_\_ FAX/EMAIL: \_\_\_\_\_ NPI # \_\_\_\_\_

I understand that the medical record may include information relating sexually transmitted disease, AIDS, HIV, behavioral or mental services, and treatment for alcohol and drug abuse. The records may be disclosed to and used by **ORLANDO HYPERBARICS**. 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, has been explained to me. Any revocation should be sent to **Orlando Hyperbarics** at the address indicated above. Unless, revoked, this authorization will expire on the following date or condition: \_\_\_\_\_  
Otherwise, this authorization will expire in one year. I understand that the revocation will not apply to any information that has been released as a result of this authorization. The authorization to disclose health information is voluntary. I am aware that this information is subject to disclosure by the recipient and may no longer be protected by the Privacy Rule.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

Dear Doctor \_\_\_\_\_,

Your patient listed above has contacted us to receive HYPERBARIC OXYGEN TREATMENT. Below is a list of FDA approved conditions which are covered by the patient's insurance. Please indicate which condition they have been treated for and forward to us the supporting medical records.

- o If you have not treated the patient for the ailment(s) in which they are seeking HBOT, please check here if you would like the patient referred back to your office for a current office visit.

039.0	Cutaneous actinomycotic infection	996.91	Complications of reattached forearm
039.1	Pulmonary actinomycotic infection	996.92	Complications of reattached hand
039.2	Abdominal actinomycotic infection	996.93	Complications of reattached finger(s)
039.3	Cervicofacial actinomycotic infection	996.94	Complications of reattached upper
039.4	Madura foot/Mycetona		extremity, other and unspecified
039.8	Actinomycotic infection of other specified sites	996.95	Complications of reattached foot or toe (s)
039.9	Actinomycotic infection of unspecified sites	996.96	Complications of reattached lower extremity
040.0	Gas gangrene		other and unspecified
444.21	Embolism and thrombosis of arteries of upper extremities	250.70-250.83	Diabetic wounds w/ type I or II diabetes
444.22	Embolism and thrombosis of arteries of lower extremity	987.7-989.0	Cyanide poisoning
444.81	Embolism and thrombosis of iliac artery	986.0	Acute carbon monoxide
526.89	Other specified diseases of the jaws	993.3	Decompression illness
728.86	Necrotizing fasciitis	999.1	Air embolism as complication medical care
730.10	Chronic osteomyelitis, site unspecified	250.70-250.73	Diabetes w/ peripheral circulatory dis.
730.11	Chronic osteomyelitis, shoulder region	250.80-250.83	Diabetes w/ other specified manifestation
730.12	Chronic osteomyelitis, upper arm	958.0	Gas embolisms
707.12-707.13	Ulcer of calf/ankle	996.52/996.55	Prep/pres. of compromised skin grafts
707.14	Ulcer of heel and midfoot	902.53-904.7	Acute traumatic peripheral ischemia
707.19	Ulcer of other part of lower limb	925.1-929.9	Crush injuries and suturing of severed limbs

**Patient Authorization**

**To the Patient:**

Orlando Hyperbarics will file your primary insurance, and/or Medicare, as well as your secondary insurance. We ask that you **DO NOT FILE** with your insurance company, but that you supply this office with the necessary forms or information needed to file your claim for services rendered to you. You will be expected to pre-pay for the first 30 days of service until the insurance company has started making payments accepting the claim. You are then reimbursed for advance payments you make. We make every effort to receive full benefits. If we cannot get coverage from your insurance, you will need to pay on a self-pay basis. We know questions can arise on insurance matters and should be discussed with our insurance person.

With every insurance company, advance authorization, notice or approval is not a guarantee of payment, only the receipt of their check is guarantee of payment. When they begin payments, they have accepted the claim. We appreciate your advising this office of any changes in your address, phone number, insurance coverage, or employment.

**PATIENT AUTHORIZATION:**

I, \_\_\_\_\_, hereby authorize Orlando Hyperbarics  
Patient name  
to apply for benefits on my behalf for covered services rendered. I request payment from BCBS/Carefirst, Choice, Blue Shield of Florida, Medicare, and/or other insurance as listed here \_\_\_\_\_ be made directly to the above named party who accepts assignment.

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, to BC/BS, Carefirst, Blue Choice Carefirst of Florida (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or \_\_\_\_\_. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or by the above named carrier at any time in writing.

\_\_\_\_\_  
*Signature of Patient, Subscriber, or Beneficiary*



**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 also understand you are not required to agree to my requested restrictions; but if you do agree, you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Patient or Legal Caregiver’s Signature \_\_\_\_\_ Date: \_\_\_\_\_

If Caregiver, what relation to patient: \_\_\_\_\_

---

**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:

Date:	Initials:	Reason:
-------	-----------	---------

**PATIENT CONSENT FORM**

NAME OF PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

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

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 Orlando Hyperbarics of any other oxygen treatments I am receiving from any other facility.

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 I acknowledge that no guarantees have been made to me concerning the results of examination or treatments from this therapy.

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
Signature of Patient or Representative

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:

\_\_\_\_\_  
\_\_\_\_\_

## PREPAYMENT REFUND POLICY

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, full price for each treatment will be deducted from the payment. The remaining balance, if any, will be refunded by company check payable to the payment source.

## APPOINTMENT CANCELLATION POLICY

We require 24 hours notice to cancel appointments without charge. Appointments canceled with less than 24 hours notice will be charged the full treatment amount as specified in your treatment package.

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

---

Signature of Patient or Representative

---

Witness