HYPERBARIC MEDICAL SOLUTIONS

NAME:_____ DATE OF BIRTH:_____ DATE:_____

Dear Patient,

Our team at Hyperbaric Medical Solutions is pleased to welcome you to our state-of-the-art Hyperbaric Oxygen Therapy facility. We aspire to bring the revolutionary healing powers of Hyperbaric Oxygen Therapy to all with a health condition that may benefit from increased oxygen concentration and absorption in the body. By breathing pure oxygen in one of HMS's private pressurized acrylic chambers, a greater amount of oxygen is able to be dissolved in the bloodstream to promote healing in the body.

The experienced physicians and medical staff at HMS are here to help you. They are passionate about Hyperbaric Oxygen Therapy and they are confident that their customized treatment protocols they design for each HMS patient will lead to better health and overall well-being.

We hope that your experience here at HMS is pleasant and successful. Our patients are our number one priority and our goal is to make you as comfortable as possible. Throughout your time here, please do not hesitate to let us know how we can make your experience better.

Prior to arriving for your consultation appointment, please complete and sign the documents found in the welcome packet. This will greatly help the staff at HMS make your visit to our facility seamless and enjoyable. Also, please remember to bring your insurance card and one form of photo identification with you to your initial appointment.

Yours truly,

The Hyperbaric Medical Solutions Team

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NAME:_____ DATE OF BIRTH:_____ DATE:_____

Address: _____ City: _____ State: ____ Zip: _____

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

Email: _____ Date of Birth: _____ SSN: _____ - ____ - _____

Gender: Male ☐ Female ☐ Marital Status: _____

Preferred Method of Contact: Phone ☐ Text ☐ Email ☐

How did you hear about HMS? _____

Race: Caucasian ☐ Hispanic ☐ African American ☐ Native American ☐ Other ☐_____

Ethnicity: _____ Language: English ☐ Other ☐ _____

Emergency Contact: _____ Relationship:_____

Emergency Contact Phone:_____ Alt Phone: _____

Chief Complaint/Reason for Visit:

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NAME:_____ DATE OF BIRTH:_____ DATE:_____

Care Providers

Primary Care Doctor: _____ PCP Phone: _____

Referring Doctor: _____ Ref Dr. Phone: _____

Other Providers

Name: _____ Contact Number: _____

Name: _____ Contact Number: _____

Name: _____ Contact Number: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Claim Address: _____ Claim Address: _____

Identification #: _____ Identification #: _____

Insured Name: _____ Insured Name: _____

Group #: _____ Group #: _____

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Workman's Compensation Information *(complete only if applicable)*

Is the reason for your visit due to a work-related accident? ☐ *(If yes, please check and complete the following.)*

Date of Injury or Accident: _____

Carrier: _____ Name of Adjuster: _____

Carrier Case/Claim#: _____ Contact Number: _____

WCB Case/Claim#: _____

No Fault Information *(complete only if applicable)*

Is the reason for your visit due to a motor vehicle accident? ☐ *(If yes, please check and complete the following.)*

Date of Injury or Accident: _____

Carrier: _____ Carrier Case/Claim#: _____

Policy Holder Name: _____ Policy #: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: _____

Name of Adjuster: _____ Contact Number: _____

Briefly describe the accident and how and where the patient's injury occurred:

Attorney Information

Law Firm Name: _____ Address: _____

Name of Attorney Handling Case: Contact Number: _____

_____ Fax Number: _____

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PATIENT & FAMILY HISTORY

Patient

Has the patient previously received hyperbaric oxygen therapy?	Yes ☐ No ☐

Has the patient had a chest X-Ray	Yes ☐ No ☐
If so, what is the approximate date of CXR and where was it received?	
Is, or could be, the patient currently pregnant?	Yes ☐ No ☐

Current Implanted Device(s)

None	☐	Pacemaker / Defibrillator	☐
Glucose Monitor	☐	Pain Pump	☐
Insulin Delivery System	☐	VP Shunt	☐
Other _____	☐		

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History of *(check all that apply)*:

Pneumothorax / Collapsed Lung	☐	Pulmonary blebs	☐
Current use of Antabuse	☐	Eustachian tube dysfunction (problems with ear drum)	☐
Chemotherapy	☐	Radiation Therapy	☐
Claustrophobia	☐	Congenital Spherocytosis	☐
Congestive Heart Failure or Heart Problems	☐	Seizures	☐
Middle Ear Surgery	☐	Severe Aortic Stenosis	☐
Other _____	☐	None	☐

History of *(check all that apply)*:

Hypertension	☐	Diabetes	☐
Hypercholesterolemia	☐	Cancer (Type: _____)	☐
Heart Disease	☐	Asthma	☐
COPD / Emphysema	☐	Stroke	☐
Seizure Disorder	☐	Other _____	☐

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If Chemotherapy checked above, what type:

Bleomycin	☐	Adriamycin	☐
Doxorubicin	☐	Cisplatin	☐
Carboplatin	☐	Other _____	☐

Surgical History *(check all that apply)*:

Tonsillectomy	☐	Thyroidectomy	☐
Cholecystectomy	☐	Appendectomy	☐
Mastectomy	☐	Other _____	☐

Please note surgery date where applicable.

Family

Does anyone in your family have a history of the following (*Please check **all** that apply)*:

Cancer	☐	Diabetes	☐
Heart attack	☐	Stroke	☐
Hypertension	☐		

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MEDICATIONS / SUPPLEMENTS & ALLERGIES

Current Medications and/or Supplements

Is the patient on any medications? If yes, please list their names.

Medication Name	Supplement Name

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Allergies

Allergic to Latex: Yes ☐ No ☐
Medication Allergies: Yes ☐ No ☐
(Please List:)

Medication Name	Reaction

Patient or Responsible Party		
Signature	**Print**	**Date**

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YOUR RIGHTS

Among other things, you have the right to:

- Request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations.
- Reasonably request to receive communications by alternative means or at alternative locations.
- Inspect and copy certain protected health information contained in your medical and billing records and in any other records used by us to make decisions about you.
- Request an amendment to your protected health information, but we may deny your request for amendment, in certain circumstances.

COMPLAINTS AND CONTACT PERSON

- You also may file a complaint with the Secretary of Health and Human Services. If you have any questions or would like further information about our notice, please contact **the HMS Administrative Department**, at 516-802-5025.

This notice is effective as of January 2, 2012.

Acknowledgement

I, _____, acknowledge that I have been provided with a copy of Hyperbaric Medical Solution's privacy notice.

Patient or Responsible Party		HMS Representative	
Signature	Date	Signature	Date

HIPAA PRIVACY NOTICE SUMMARY

HYPERBARIC MEDICAL SOLUTIONS

NAME:_____ DATE OF BIRTH:_____ DATE:_____

THIS IS A SUMMARY OF HYPERBARIC MEDICAL SOLUTIONS' PRIVACY NOTICE AND IS NOT COMPLETE WITHOUT REFERENCE TO THE ATTACHED PRIVACY NOTICE. IF YOU HAVE NOT RECEIVED THE PRIVACY NOTICE, PLEASE REQUEST IT FROM HMS ADMINISTRATIVE STAFF.

Hyperbaric Medical Solutions (HMS) understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care (your "protected health information").

OUR USES AND DISCLOSURES

- Your protected health information will be used, as needed, by HMS, its personnel and its Medical Staff for purposes of treatment, payment and HMS's routine health care operations.
- We may use your protected health information in a variety of other ways, although all such uses and disclosures will be subject to the restrictions of applicable law. For example, we may:
  - contact you to provide appointment reminders for treatment or to recommend possible treatment alternatives;
  - disclose information to your family or friends or any other individual identified by you who is involved in your care or the payment for your care;
  - include your name and one-word description of your condition in our directory while you are a patient at the Hospital;
  - in certain circumstances, allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, or X-rays;
  - contact you as part of our fundraising and marketing efforts;
  - disclose your health information to conduct certain research activities; and
  - disclose your health information to comply with laws applicable to the Hospital.
- Other uses and disclosures of protected health information not covered by our notice or the laws that apply to us will be made only with your permission in a written authorization.

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HIPAA Authorization

This waiver authorizes Hyperbaric Medical Solutions to send and/or receive my medical information as noted:

- Leave a voicemail recording including my Personal Health information on my home/cell phone — Yes ☐ No ☐
- Leave a voice mail recording including my personal health information on my business phone — Yes ☐ No ☐
- Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription treatment, disorder related information, lab or other results — Yes ☐ No ☐
- Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the internet). — Yes ☐ No ☐
- Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results information — Yes ☐ No ☐
- Use of e-mail to transmit electronic billing statements — Yes ☐ No ☐
- Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information — Yes ☐ No ☐

Name of Personal Representative_____

Acknowledgement

I, _____, acknowledge that I have received and reviewed Hyperbaric Medical Solutions' Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can access this information. I acknowledge that HMS may use electronic signatures to request and obtain medical records from other providers with the HIPAA medical release form via secure, HIPAA compliant electronic systems.

Patient or Responsible Party		HMS Representative	
Signature	Date	Signature	Date

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