

Welcome

**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.**

to The Hyperbaric Therapy Center Of Rome

Patient Information (CONFIDENTIAL)

Name: _____ Date: _____
Soc. Sec. #: _____

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: _____

Who May We Thank for Referring You? _____

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

What Is Your Primary Reason for Coming to the Hyperbaric Therapy Center?

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

1. Are you under medical treatment now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	5. Do you use alcohol? If so, how much? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Do you exercise on a regular basis? If so, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>	6. Are you pregnant or think you may be pregnant? If so, how many weeks? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you use tobacco? If so, please explain? _____					
4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you taking any medication(s)? If yes, what medication(s) are you taking? _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

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

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	Infections, Frequent	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cough, Chronic	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/ Implant	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic/Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Lung Infection, Frequent	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had any ear problems?				<input type="checkbox"/>	<input type="checkbox"/>			
10. Do you have any problems with your ears when you fly?				<input type="checkbox"/>	<input type="checkbox"/>			
11. Do you have any problems going up and down in an elevator?				<input type="checkbox"/>	<input type="checkbox"/>			
12. Do you have back problems?				<input type="checkbox"/>	<input type="checkbox"/>			

Notes or 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 medical treatment. I authorize The Hyperbaric Therapy Center of Rome to use photographs of me in education presentations. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (parent or guardian) _____ Date _____

Doctor's Comments: _____ Date: _____

Hyperbaric Therapy Consent Form

You are about to begin your first hyperbaric visit. This technology, known as mild hyperbaric therapy, 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: *This 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 (at the beginning of your visit) and also as it is depressurized (at the end of your visit), you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You do this by "popping" your ears. This is normal, and you can help the "popping" effect by yawning or swallowing. A more effective method is to hold your nose, close your mouth, and blow. Continue to do this each time you feel pressure build up in your ears. When the chamber reaches its full pressure, you will not have this concern. When the chamber is near completion of depressurization, you will again have no concern.*

*If one or both of your ears do not acclimate normally (by the "popping"), you will begin to experience discomfort in your ear canals. This can be caused by ear and/or throat congestion, or by prior trauma to the ears. You should not endure any ear discomfort during your visit. **IT IS THEREFORE CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE ATTENDANT.** The attendant will immediately adjust the pressure, using the pressurization valve, back to a level of comfort for you, and slowly try again to see at what level of pressure you are able to equalize the pressure in your ears. If you are unable to equalize the pressure in your ears, the visit will be immediately discontinued and reevaluated.*

PAIN FROM SINUS, HEAD COLDS OR VIRUS: *You should not schedule a visit in the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent, but it may occur in people with chronic or acute sinus infections of allergic rhinitis. If you experience discomfort from any of these conditions during pressurization, you must communicate with the attendant immediately, and the treatment will be discontinued. Steps can then be recommended that will help 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.*

I have read and fully understand the above information.

Signature _____

Date: ____/____/____

PRIVATE LICENSE

The undersigned hereby grants a Private License to the Hyperbaric Therapy Center of Rome to provide mild hyperbaric therapy to the undersigned. The undersigned acknowledges that the Hyperbaric Therapy Center of Rome 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 the Hyperbaric Therapy Center of Rome or its agents apply medical, mental health or human development principles, but rather provides hyperbaric therapy technology that may benefit.

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

The undersigned hereby releases the Hyperbaric Therapy Center of Rome 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 therefrom, whatsoever. The Institute and its agents reserve all rights.

In the unlikely event that the client has a dispute with the Hyperbaric Therapy Center of Rome, the client agrees that the dispute shall be settled by arbitration through the Better Business Bureau of Metropolitan Atlanta.

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 the Hyperbaric Therapy Center of Rome harmless from blame regarding hyperbaric therapy services provided by the Hyperbaric Therapy Center of Rome.

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, and we do not accept insurance for any of our services.

Signature _____

Date: ____/____/____

HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES THE HYPERBARIC THERAPY CENTER OF ROME TO USE AND / OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to The Hyperbaric Therapy Center Of Rome 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 _____

- If The Hyperbaric Therapy Center of Rome contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

Initial _____

- I give The Hyperbaric Therapy Center of Rome 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 _____

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 a PowerPoint educational CD, or on our website.

- I give The Hyperbaric Therapy Center of Rome permission to use my photograph or my child's photograph in printed form on display at the center.

Initial _____

- I give The Hyperbaric Therapy Center of Rome permission to use all or part of my testimonial in printed form on display at the center or during promotional events.

Initial _____

- I give The Hyperbaric Therapy Center of Rome permission to use my testimonial in digital form on a PowerPoint promotional/educational CD.

Initial _____

- I give The Hyperbaric Therapy Center of Rome permission to use my testimonial on the www.HyperbaricTherapyCenterofRome.com website.

Initial _____

- I give The Hyperbaric Therapy Center of Rome 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 _____

By signing this form you are giving The Hyperbaric Therapy Center of Rome permission to use and disclose your protected health information in accordance with the directive listed above.

EXPIRATION

This Authorization shall expire on the following date: 12-31-2012

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of The Hyperbaric Therapy Center of Rome. The written notice must contain the following information:

- Patient's name and date of birth.
- A clear statement of the intent to revoke this AUTHORIZATION;
- Request date
- Patient's signature.

The revocation is not effective until it is received by the Privacy Official.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, The Hyperbaric Therapy Center of Rome will not refuse to provide treatment.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED UPON YOUR REQUEST.

Print Name of Patient _____

Signature of Patient _____

Date _____

Signature of Personal Representative _____

Description of Representative's Authority to Act for Patient: _____