hyperbaric oxygen therapy

Patient Information **Date__________**

Name____DOB________________Sex: M / F
SSN____________________________________
Insurance______________________________Insurance ID#_____________________________________

Address____

City____ State_____________
Zip____________________________________

Home phone__________________________ Cell phone_____________________
Work phone___________________________ Please circle best # to reach you

E-mail____________________________________ Fax_____________________

Minor____ Single____Married____ Divorced____ Widowed____ Separated____

Legal guardian (if minor) or Guarantor____

Address ____

Spouses name (If applicable) ______________________________ Phone_______________________

Emergency Contact (If different from above) ____
Relation________________________________

Address____
Phone___________________________________Email____

Who referred you to us?
____

What is your goal with Hyperbaric Oxygen Therapy?

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Referring Physician Information

Referring physician_____________________________Pharmacy_______________________________

Address____

City_________________________ State_____________ Zip__________________

Phone__________________________Fax__________________________________

E-mail____

Patient Medical History

Current Medical treatment____

____

Current medications used ____

____

Have you ever used Bleomycin or Cisplatin? Yes / No__If yes, when did you stop? _______

Are you currently using Disulfiram, Doxorubicin or Sulfamylon? Yes / No

Do you have, or have you had: Please put a check next to all that apply and provide details on next page.

AIDS/HIV ____
Allergies ____
Anemia ____
Angina ____
Arthritis ____
Asthma ____
Bronchitis ____
Cancer ____
Chest pains ____
Chronic cough ____
Claustrophobia____
Diabetes ____
Ear surgery ____
Emphysema ____
Epilepsy ____
Fainting ____

Glaucoma ____
Hay fever ____
Hepatitis ____
Heart attack ____
Heart disease ____
Heart murmur ____
Herpes ____
Hypertension ____
Hypotension ____
Infections ____
Joint replacement__
Kidney disease____
Leukemia ____
Liver Disease ____
Lung disease ____

Mitral valve prolapse___
Neurological disease___
Pacemaker ____
Pneumothorax ____
Radiation therapy ____
Respiratory problems___
Rheumatic fever ____
Rosacea ____
Seizures ____
Stomach problems ____
Stroke ____
Thoracic surgery ___
Thyroid problems ____
Tuberculosis ____
Weight gain/loss ____

Provide details of any conditions checked off on previous page

____

____

____

____

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____

____

Any ear problems while flying, diving, swimming, in elevators or otherwise?

____

Any back problems? ____

Any other concerns you or your doctor may have with Hyperbaric Oxygen Therapy?

____

____

Please read and initial each of the statements below and sign the bottom:

I hereby certify the information provided is correct and true to the best of my knowledge_____.

I am responsible for the payment of all services rendered_____.

____ ________________
Signature of patient/client or parent/guardian date

100 Jenkins Ranch Rd, Ste D, Durango, CO 81301 * 970-403-5453 * mountainhyperbarics@gmail.com

hyperbaric oxygen therapy

Medical Records Release

Patient Name____DOB_________________________
Address____
Phone Number___________________________Social Security Number________________________

Records to be released from____
Address____
Phone Number_____________________________Fax Number______________________________

Records to be released to: Mountain Hyperbarics
100 Jenkins Ranch Rd, Ste D
Durango, CO 81301

Phone Number: 970-403-5453 Fax Number: 970-444-7043

Type of Records: All_____ Records Dated_________________________

I understand that this medical release may include records concerning treatment of both physical and mental illness, drug/alcohol abuse, and records of sexually transmitted diseases. I also understand that this release is only valid for one year. I may revoke the authorization in writing at any time. There is no fee to provide records to another health provider. There will be a fee to provide records to any other party, such as attorney, insurance company, etc.

Print Name____

Signature____Date________________

Disclosures

Hyperbaric Oxygen Therapy (HBOT) has been shown to be effective and beneficial in treating a wide variety of conditions and diseases. Hyperbaric Oxygen Therapy (HBOT) is not a stand-alone cure for any condition or disease and results vary. No therapeutic outcome can be guaranteed. Hyperbaric Oxygen Therapy (HBOT) is not meant to replace any treatments prescribed or suggested by your primary physician.

Mountain Hyperbarics does not accept insurance and payment must be made at the time of service. Mountain Hyperbarics has opted out of Medicare and therefor does not qualify for reimbursement by Medicare. Mountain Hyperbarics does not accept, bill, or have responsibility for any private medical insurance carrier's payment of a patients claim for reimbursement. Multiple treatments may be paid in advance and may be eligible for substantial discounts.

In the unlikely event of a dispute between the patient or client and Mountain Hyperbarics, both parties agree that the dispute shall be settled by binding arbitration.

Please read and initial and/or sign each of the statements below:

The patient has read the above disclosures_____.

The patient or patient's legal representative agrees not to submit a claim to Medicare or ask Mountain Hyperbarics to submit a claim to Medicare_____.

The patient or patient's legal representative understands that Medicare payment will not be made for any items or services provided by Mountain Hyperbarics. This includes any items or services that may have been previously covered by Medicare_____.

Mountain Hyperbarics does not accept, bill, or have responsibility for any private medical insurance carrier's payment of a patients claim for reimbursement_____.

The patient has read the Contraindications to Hyperbaric Oxygen Therapy_____.

The Patient has read the Guidelines for Chamber Occupants (as appropriate) and agrees to abide by them_____.

The patient has read the Notice of Privacy Practices_____.

____ ________________________________
Patient/Client or parent or legal guardian date

An electronic or print copy of all the above documents as well as patient records are available at no charge to the client.