Community HBOT at Hardwick Chiropractic

54 School Circle ● East Hardwick, Vermont 05836

802-472-8900 ● 802-472-3022 fax ● www.CommunityHyperbaric.com

Please fill out completely and answer all questions to the best of your ability.

Name _____ Date _____

Address _____ Home Phone _____

City _____State _____ Zip _____ Business Phone _____

Email _____ Cell Phone _____

Date of Birth _____ Age ____ Male ❑ Female ❑ Married ❑ Partnership ❑ # of Children ___

Occupation _____

Emergency Contact (Name): _____ Email: _____

Phone (Home): _____ Phone (Cell):_____

How did you hear about Community Hyperbaric Oxygen Therapy? _____

Referring Physician _____

Address _____ Phone _____

City _____State _____ Zip _____

Additional Physician _____

Address _____ Phone _____

City _____State _____ Zip _____

What is the reason you seek Hyperbaric Oxygen Therapy? _____

_____

Medical History and Medications

Are you currently undergoing medical treatment? Please describe. _____

_____

If you exercise on a regular basis, how frequently? _____

If you use tobacco, how frequently? _____

If you use alcohol, how frequently? _____

Are you pregnant or think you may be pregnant? ❑ No ❑ Yes

Have you ever had any ear problems? ❑ No ❑ Yes Please describe. _____

_____

Do you have any problems with your ears when you fly? ❑ No ❑ Yes

Are you currently prescribed or taking any of the following medications? Check all that apply.

- ❑ Bleomycin
- ❑ Cis-Platinum
- ❑ Disulfiram (Antabuse)
- ❑ Doxorubicin (Adriamycin)
- ❑ Mafenicide Acetate (Sulfamylon)

Have you ever had or been suspected of having any of the following conditions? Check all that apply.

- ❑ COPD
- ❑ Hereditary Congenital Spherocytosis
- ❑ Severe Emphysema
- ❑ Sickle Cell Anemia
- ❑ Untreated Pneumothorax

Have you ever had radiation therapy? ❑ No ❑ Yes Please describe. _____

Have you had or do you currently have any of the following? (Version 9/19/13)

- ❑ Acute Respiratory Illness
- ❑ Allergies
- ❑ Anemia
- ❑ Angina/Chest Pain
- ❑ Anxiety
- ❑ Arthritis
- ❑ Aspergers/Autism
- ❑ Asthma
- ❑ Back Pain
- ❑ Balance Problems
- ❑ Bells Palsy
- ❑ Cancer or Malignant Tumor
- ❑ Cataracts
- ❑ Cerebral Palsy
- ❑ Chemical sensitivity
- ❑ Chemotherapy
- ❑ Chronic Back Problems
- ❑ Chronic Bronchitis
- ❑ Chronic Fatigue
- ❑ Claustrophobia or Panic Attacks
- ❑ Congenital Spherocytosis
- ❑ Crohns Disease
- ❑ COPD/Lung Disease
- ❑ Dementia
- ❑ Diabetes Type 1 Type 2
- ❑ Dizziness
- ❑ Ear Infections (frequent)
- ❑ Ear Trauma
- ❑ Emphysema
- ❑ Epilepsy or Seizure Disorder
- ❑ Exposed Bone
- ❑ Fainting
- ❑ Fever – current
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Headache
- ❑ Heart Attack
- ❑ Heart Disease/Heart Problems
- ❑ Heart Failure
- ❑ Heart Murmur
- ❑ Hepatitis/Jaundice
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV Infection/AIDS
- ❑ Infections (frequent)
- ❑ Insomnia
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Infections (frequent)
- ❑ Lyme Disease
- ❑ Migraines
- ❑ Mitral Valve Prolapse
- ❑ MRSA (Staphylococcus)
- ❑ Multiple Sclerosis
- ❑ Neurological Disease
- ❑ Optic Neuritis
- ❑ Parkinson's
- ❑ Pneumothorax/Collapsed Lung
- ❑ Pregnant – current
- ❑ Pulmonary Cysts or Abscesses
- ❑ Radiation Therapy
- ❑ Recent Dental Surgery
- ❑ Recent Weight Loss/Gain
- ❑ Rheumatoid Arthritis
- ❑ Ringing in the Ears
- ❑ Rosacea
- ❑ Sinusitis
- ❑ Sleep Apnea
- ❑ Stomach Problems/Ulcers
- ❑ Stroke
- ❑ Swollen Ankles
- ❑ Thyroid Problems
- ❑ Transient Ischemic Attacks
- ❑ Traumatic Brain Injury
- ❑ Tuberculosis

- ❑ Upper Respiratory Infection
- ❑ Viral Infection – current
- ❑ Other _____

Please list types of surgeries and dates.

Type of surgery: Date:

_____ _____

_____ _____

_____ _____

_____ _____

Have you been hospitalized for any serious illnesses within the last 5 years?

❑ No ❑ Yes Please describe. Include dates. _____

_____

_____

Are you taking any medications (prescription or over-the counter)? ❑ Yes ❑ No

List medication(s): To treat: Duration/For how long?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Were you previously taking any medication regularly? _____

Please list current allergies. _____

I certify that all of the information above is true and accurate. I **agree to advise Community Hyperbaric of any changes in my patient information, medical status, medications, allergies, or any other information** concerning my therapy.

I have reviewed the Community Hyperbaric Consent Agreement. I acknowledge the possible, but rare, side effects as indicated and am aware of contraindications to oxygen therapy. I also understand my responsibilities as a Community Hyperbaric patient in terms of preparing for my therapy sessions.

I have reviewed the fee schedule and understand that I am responsible for payment on the date of service.

Signature _____ Date _____

CONSENT TO TREATMENT OF A MINOR

I hereby authorize staff at Community Hyperbaric to administer mild hyperbaric oxygen therapy to

_____.

Guardian's Signature _____ Date _____ Witnessed by _____

Consent For Use or Disclosure of Health Information

Our Privacy Pledge

Community Hyperbaric Oxygen Therapy (HBOT) is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

We may send you correspondence in the form of postcards, birthday cards, thank you letters, health information, newsletters, and other information. We may also send gift certificates for referring others patients to us. You have the right to refuse such correspondence.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy practices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

We may need to use your name, address, phone #, e-mail, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ Print Name	_____ Authorized Provider Representative
_____ Signature	_____ Date
_____ Date	

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Consent Agreement to Treatment

Please read the following statements and acknowledge by signing below.

- I understand that mild hyperbaric oxygen therapy is not intended to diagnose, treat, cure, or prevent disease. In addition, I recognize that while mild hyperbaric oxygen therapy may enhance healing, it does not replace a health professional's prescribed medications or recommended treatments. Health professionals prescribe mild hyperbaric oxygen therapy to address a wide variety of health issues; however, I acknowledge this therapy is only FDA approved for specific conditions.

- I understand that mild hyperbaric oxygen therapy uses an increase in atmospheric pressure in a sealed chamber to allow the body to absorb more oxygen (approximately 91%) at a cellular level to promote healing and wellness. I understand that the amount of atmospheric pressure used by Community Hyperbaric is 1.3 absolute atmospheres, or 4.4 psi.

- I understand that mild hyperbaric oxygen therapy is reported to be beneficial for a wide range of medical ailments, but no therapeutic outcomes can be guaranteed. I recognize that while the FDA recognizes specific conditions that directly benefit from mild hyperbaric oxygen therapy, there are many additional "off- label" conditions, which have been studied with positive results. As with any therapy, there are no guarantees as to any positive physical or emotional response, and the fees are for services rendered and not benefits received. I procure this therapy at my own risk. I understand that I may neither observe nor realize any benefit from the hyperbaric treatment. I understand that mild hyperbaric oxygen therapy is not a substitute for any medical treatment prescribed or suggested by my physician.

- I understand that as the chamber is pressurized and depressurized I may need to equalize the pressure in my ears to acclimate to the pressure changes and may experience "popping" in my ears. This is normal**. If I am unable to equalize ear pressure and experience pain in one or both ears, I will immediately communicate the discomfort, so adjustments may be made to eliminate discomfort.** If I am unable to equalize the pressure in my ears, the therapy session may be terminated or modified—therapy may be administered at a lower atmospheric pressure.

- I understand that I may experience minor ear, sinus, or other discomfort. I acknowledge that a Community Hyperbaric staff member is present to work with me to provide comfort in the event of any discomfort I may experience, but that the staff member may not be a trained health care worker. I understand that Community Hyperbaric is not a medical facility.

- I attest that I am a consenting adult over the age of 18 and that I agree to enter (and/or permit my child to enter) the mild hyperbaric chamber of my own free will. I am entering the chamber at my own risk and without the coercion or sales pressure from any associate or employee of Community Hyperbaric or Hardwick Chiropractic.

~Over~

- I am not aware of any physical conditions of which I suffer or have that would or should preclude my undertaking this therapy. If I have any doubts, concerns, or questions, I will, prior to undertaking such therapy, see and obtain medical advice from a licensed physician. In addition, I understand that it is my sole responsibility to update Community Hyperbaric regarding any changes to my medical status or medications each time I receive treatment.

By signing I attest to the fact that I have fully read, understood, and consented to this agreement in its entirety to treatment(s) in the mild hyperbaric chamber. I understand that by signing this I am assuming any and all risks associated with the administration of mild-pressure hyperbaric oxygen chamber therapy. I agree not to hold **Community Hyperbaric** or **Hardwick Chiropractic, Inc** *liable for any harm I may associate with the treatment(s) in the mild hyperbaric chamber.*

Acknowledgement of Policies

- Your treatment here is our priority. We appreciate 24 hour notice for cancellations. We are happy to reschedule your treatments at your convenience. Missed appointments will incur the usual treatment fee.
- I understand that it is important to arrive 10 – 15 minutes before my treatment time in order to prepare to enter the chamber as scheduled. Should I arrive late, I understand that my treatment will end at the scheduled time in order to keep other patients appointments timely.
- I agree not to bring food or drink into the chamber. I understand that the exception to this rule is if I have diabetes, in which case I will bring an appropriate snack to each session in case my blood sugar drops during treatment. I also agree not to bring flammables into the chamber.
- I understand that it is important to have eaten food at least one hour prior to treatment.
- I understand that smoking and nicotine interfere with the benefits of mild hyperbaric oxygen therapy. Therefore, I agree to abstain from smoking or using a nicotine patch 2 hours prior to my appointment time.

By signing I attest to the fact that I have fully read, understood, and consented to this agreement in its entirety and to treatment(s) in the mild hyperbaric chamber. I understand that by signing this I am assuming any and all risks associated with the administration of mild-pressure hyperbaric oxygen chamber therapy. I agree not to hold **Community Hyperbaric** or **Hardwick Chiropractic, Inc.** *liable for any harm I may associate with the treatment(s) in the mild hyperbaric chamber.*

_____ Print Name	_____ Authorized Provider Representative
_____ Signature	_____ Date
_____ Date	

Disclaimer—The content and information provided by Community Hyperbaric is for informational and educational purposes only and is not intended as medical advice. Please consult a physician before pursuing any form of medical treatment, including hyperbaric oxygen therapy. No claims are made as to the effectiveness of hyperbaric oxygen therapy in the treatment of specific conditions. Community Hyperbaric Oxygen Therapy makes no express or implied warranty regarding any health benefits that may be derived from the use of a hyperbaric chamber. A portable hyperbaric oxygen chamber is a Class II Medical Device, and as such its use or purchase requires a physician's prescription.

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication.

If you use these methods to communicate with Hardwick Chiropractic/ Community Hyperbaric there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

* People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
* Your employer, if you use your work email to communicate with Hardwick Chiropractic/Community Hyperbaric.
* Third parties on the Internet such as server administrators and others who monitor Internet traffic.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I _____consent to allow Hardwick Chiropractic/Community Hyperbaric to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:
* Information related to the scheduling of meetings or other appointments
* Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time by giving written notice to Hardwick Chiropractic/ Community Hyperbaric at the above address.

Signature:_____ Date:_____