HYPERBARIC MEDICAL SOLUTIONS

Patient Registration

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

Medford
12 Platinum Ct
Medford, NY 11763
631.504.6800

Woodbury
80 Crossways Park Drive
Woodbury, NY 11797
516.802.5025

Manhattan
160 East 32nd Street
New York, NY 10016
646. 742.8888

hyperbaricmedicalsolutions.com • forms@hyperbaricmedicalsolutions.com

HYPERBARIC MEDICAL SOLUTIONS

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: _____

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:_____

Employment Information

Occupation: _____ Employer Name:_____

Address: _____ Phone: _____

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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NAME:_____ DATE OF BIRTH:_____ DATE:_____

Workman's Compensation Information

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

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

Height: _____	Weight: _____ (lbs)

Please check **all** that apply:

Current Smoker	☐	History of Congenital Spherocytosis	☐
History of Smoking	☐	History of Eustachian tube dysfunction (problems with ear drum)	☐
Date Quit: _____		History of claustrophobia (fear of enclosed spaces)	☐
Currently using Antabuse	☐	History of Pneumothorax or Pulmonary blebs	☐
Are you pregnant?	☐	History of Congestive Heart Failure or Heart Problems	☐
		Currently have any implanted devices	☐

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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Surgeries & Hospitalizations

Does the patient have a history of any surgery or past hospitalizations? Yes ☐ No ☐

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Recent Test Dates and Contacts

Test	Location	Date	Ordering Physician	Contact Number
Last Chest X-Ray:				
Last Echocardiogram:				
Last Pulmonary Function (Lung) Test:				
Last Vascular Study:				
Last Blood Work:				
Last Urine Test:				
Last Ophthalmologist Exam:				
Last Podiatry Exam:				
Last testing related to the reason of visit:				
Last Flu Shot:	N/A		N/A	N/A

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MEDICATIONS / SUPPLEMENTS & ALLERGIES

Medications and/or Supplements

Is the patient on any medications? If yes, please list them below and how often.

Drug: _____ Dose:_____ Route: _____ How often: _____

Drug: _____ Dose:_____ Route: _____ How often: _____

Drug: _____ Dose:_____ Route: _____ How often: _____

Drug: _____ Dose:_____ Route: _____ How often: _____

Drug: _____ Dose:_____ Route: _____ How often: _____

Allergies

Medication Allergies: Yes ☐ No ☐
(Please List:)

Food Allergies: Yes ☐ No ☐
(Please List:)

Drug	Reaction	Food	Reaction

Is the patient taking any IV medication? Yes ☐ No ☐

If yes, what is the patient's access site? _____

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HISTORY / SYMPTOMS / COMPLAINTS

*Check **Only** That Apply*

Pain Assessment

Do you have pain? ☐

Pain level 1-10 (1-Low; 10-High) ___

Please describe:
(location, duration, type)

_____

Allergy / Immunology

Environmental allergies ☐
Cough history ☐
Hives history ☐
Itching history ☐
Rash history ☐

Endocrine

Diabetes ☐
Thyroid disease ☐
Cold or heat intolerance ☐
Difficulty sleeping ☐
Dizziness ☐
Excessive sweating ☐
Weight loss/weight Gain ☐

Infectious Diseases

Lyme Disease ☐
Strep infections ☐

Skin

Itching ☐
Eczema ☐
Hives, rash, blistering skin ☐
Skin cancer ☐
Skin lesions ☐
Psoriasis ☐

Eyes

Retinal Bleed ☐
Cataracts ☐
Glasses or Contacts ☐
Glaucoma ☐
Optic Neuritis ☐

Ears / Nose / Throat

History of ear tubes ☐
Decreased hearing ☐
Decreased sense of smell ☐
Decreased sense of taste ☐
Difficulty swallowing ☐
Ear pain or drainage ☐
Nosebleeds ☐
Ringing in ears ☐
Chronic sinus problems ☐

Respiratory

Asthma ☐
Pneumonia ☐
Bronchitis ☐
Chronic frequent coughs ☐
Coughing up blood ☐
History of Tuberculosis ☐
Shortness of breath ☐
Emphysema ☐

Cardiovascular

Congestive heart failure ☐
Rapid/Slow/Irregular Heartbeat ☐
Defibrillator or pacemaker ☐
Heart attack ☐
Chest pain ☐
Stroke ☐
Cardiac defects ☐

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Gastrointestinal

- Ileitis/Colitis/Crohn's/Ulcerative Colitis ☐
- History of intestinal infections ☐
- Abdominal pain ☐
- Blood in stool ☐
- Heartburn ☐
- Decreased appetite ☐
- Nausea/Vomiting ☐
- Hereditary anemias ☐
- Clotting disorder ☐
- Easy bruising ☐
- Change in bowel habits (Constipation/Diarrhea) ☐

Genitourinary

- Blood in urine ☐
- Difficulty urinating ☐
- Nocturia (urinating at night) ☐
- Times/Night _____
- Frequency ☐
- Incontinence ☐

Peripheral Vascular

- Decreased sensation (Neuropathy) ☐
- Arterial disease (Decreased Circulation) ☐
- Painful extremities at rest or with exercise ☐
- Ulceration of feet/lower extremity ☐
- Have any recent vascular studies? ☐
- Name of doctor who performed study: _____

Musculoskeletal

- Scoliosis ☐
- Sciatica ☐
- Difficulty walking ☐
- Painful swollen joints ☐
- Paralysis ☐
- Arthritis ☐

Neurologic

- Migraines ☐
- Frequent/Recurring headaches ☐
- ADD/ADHD ☐
- Balance difficulty ☐
- Difficulty speaking ☐
- Dizziness ☐
- Fainting ☐
- Gait abnormality ☐
- Memory loss ☐
- Seizures ☐
- Tics ☐
- Tingling/Numbness ☐
- Tremor ☐

Psychiatric

- Aggressive behavior ☐
- Anxiety ☐
- Auditory/Visual hallucinations ☐
- Delusions ☐
- Depressed mood ☐
- Difficulty sleeping ☐
- Eating disorder ☐
- Substance abuse ☐

Oncology

- History of Cancer? ☐
- If so, what type? _____
- If so, radiation? ☐
- If so, chemotherapy? ☐
- With Bleomycin? ☐
- Currently using Sulfmylon ☐

For Women Only:

- LMP: ☐
- Irregular menses ☐
- Possibility of pregnancy ☐

For Children Only:

- Newborn problems ☐
- NICU ☐
- Breast feed ☐
- Bottle feed ☐

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CURRENT TREATMENTS / THERAPIES

Please check the types of therapies the patient is receiving and frequency:

Type		Frequency	Type		Frequency
Physical Therapy	☐	_____	Vision Therapy	☐	_____
Occupational Therapy	☐	_____	Nutrition Therapy	☐	_____
Speech Therapy	☐	_____	Acupuncture	☐	_____
Other	☐	_____			

Patient or Responsible Party		HMS Representative	
Signature:	Date:	Signature:	Date:
Print Name:		Print Name:	

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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 front desk staff at HMS**, 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:
Print Name:		Print Name:	

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HYPERBARIC MEDICAL SOLUTIONS

NAME:_____ DATE OF BIRTH:_____ DATE:_____

HIPAA PRIVACY NOTICE SUMMARY

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.

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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NAME:_____ DATE OF BIRTH:_____ DATE:_____

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:
Print Name:		Print Name:	

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