History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking	☐fever	☐ chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐ palpitations	☐vascular disease	☐valve problems	☐**NONE**
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain	☐heartburn	☐blood in stool ☐vomiting	☐ulcers	☐constipation
	☐diarrhea	☐trouble swallowing	☐decrease appetite	☐increase appetite	☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin ☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders ☐**NONE**
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			☐**NONE**
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis ☐**NONE**
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			☐**NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Rev 12/29/2011

Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc.

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend

☐ Other: _____

What is the reason for your visit today? _____

_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Rev 12/29/2011

Andrea Hyperbaric Wound Care & Health Center

Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Race: _____ ☐I prefer not to answer ☐I do not know

(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ ☐I prefer not to answer ☐I do not know

Preferred Language: _____ ☐I prefer not to answer

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker

☐ Current Some Day Smoker ☐ I decline to answer

☐ Former Smoker

Emergency Contact:

NAME: _____

Phone Number: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

ANDREA HYPERBARIC
WOUND CARE & HEALTH CENTER

HYPERBARIC PRE-TREATMENT CHECKLIST

PRE-TREATMENT CHECKLIST

	Replace Clothing with 100% cotton gown
	Remove jewelry (wedding rings may be covered)
	Remove hearing aids
	Remove contact lenses (glasses permitted)
	Remove prosthesis
	No hair spray, hair oils, make-up
	No food, candy, battery operated toys, radios, etc. or reading material
	Explain pressure & temperature changes, equalization techniques, valsalva
	Possibility of increased pain @ wound side
	Intercom, TV, Radio
	Ground Wire
	No petroleum based or Sulfamylon dressings during treatment
	Vitals on all patients, pre & post treatment
	Note all meds taken during the day
	Meal or snack within 60 minutes prior to treatment
	Signature on consent form
	Give patient HBO Information Sheet
	Blood Glucose on all diabetic patients - pre & post treatment
	Number of treatments, appointment time
	Possible side effects:
	1. Barotrauma
	2. Celebral Air Embolism, Pneumothorax O2 Toxicity, worsening myopia maturing of cataracts

Signature of Facilitator Date

Print Name

The Hyperbaric procedures have been explained to me and my questions have been answered satisfactorily

Patient Signature Date

Assignment of Benefits Form

Practice Name _____
Address _____
City, State, Zip _____
Phone _____

Date _____

Patient: _____

Employer:
_____

Claim Group: _____

SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Practice Name
Practice Address

or

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name
C/o Practice Name
Practice Address

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ (Time) this _____ (Month) day of _____ (Day), 20 _____ (Year)

_____ Signature of Policyholder

_____ Witness

ANDREA HYPERBARIC
WOUND CARE & HEALTH CENTER

Informed Consent for Hyperbaric Medicine

I, _____, hereby consent to and authorize hyperbaric oxygen therapy (HBO) and wound care to be performed on me as ordered by my physician.

I know and realize that hyperbaric medicine involves more than one treatment and I hereby authorize the performance of the number of treatments which in my physician's opinion are necessary to treat my condition.

The nature and purpose of hyperbaric medicine has been explained to me by Doctor(s) _____ and I hereby acknowledge that I know and understand the nature and purpose of these treatments. Additionally, these physicians have explained to me the benefits, consequence, risks (listed below), side effects, including potential problems that might occur during recuperation, and alternatives to hyperbaric medicine including relative risks, benefits, and side effects related to alternatives, including no treatment and have given me the opportunity to ask questions and have answered my questions concerning this matter.

Risks of Hyperbaric Oxygen Therapy:

1. Oxygen Toxicity-lung; central nervous system (seizure)
2. Barotraumas – eardrum discomfort/rupture; sinus pain
3. Myopia, reversible after HBO (nearsightedness / change in vision)
4. Increased cataract growth rate (thicken of lenses / changes in vision)
5. Lung over pressure – embolism; pneumothorax (collapsed lung/bubbles in bloodstream)
6. Safety issues

The undersigned recognizes that all persons furnishing hyperbaric services, including the physicians, are independent contractors and are not employees or agents of the associated medical facility.

I hereby consent to the performance of hyperbaric medicine.

_____ _____
Patient/Authorized Signature Date

_____
Relationship to patient

_____
Witness

_____ _____
Patient name Date

I hereby certify that I have explained the nature, purpose, benefits; likelihood of success, side effects, including potential problems that might occur during recuperation alternatives to hyperbaric medicine including relevant risks, benefits and side effects related to alternatives, including no treatment.

Physician: _____ _____ _____
(Print name) (Signature) Date

ANDREA HYPERBARIC, WOUND CARE & HEALTH CENTER

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS & GUARANTEE OF PAYMENT STATEMENTS

Account #

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND DIRECT THE ABOVE NAMED MEDICAL FACILITY AND PHYSICIANS HAVING TREATED ME, TO RELEASE TO GORERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION REGARDING MY TREATMENT.

THIS INCLUDES ALL MEDICAL RECORDS, AND TEST RESULTS NEEDED TO SUBSTANIATE PAYMENT FOR SUCH MEDICAL CARE AND TO PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE**

ASSIGNMENT TO ANDREA HYPERBARIC, WOUND CARE & HEALTH CENTER: I HEREBY ASSIGN TRANSFER AND SET OVER TO THE ABOVE NAMED MEDICAL FACILITY SUFFICIENT MONIES AND OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE TO COVER THE COSTS OR CARE AND TREATMENT RENDERED TO ME OR MY DEPENDENTS IN THIS OFFICE.

FINANCIAL AGREEMENT: THE UNDERSIGNED AGREES, WHETHER HE/SHE SIGNS AS AGENT OR AS PATIENT THAT IN CONSIDERATION FOR THE SERVICES RENDERED OR TO BE RENDERED. TO PAY ALL CHARGES INCURRED DURING THE HOSPITALIZATION OF SAID PATIENT. AND AGREE TO PAY ALL CHARGES WHICH ARE NOT COVERED BY MEDICAL INSURANCE.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE**

WITNESS FOR ANDREA HYPERBARIC, WOUND CARE & HEALTH CENTER

ANDREA HYPERBARIC
WOUND CARE & HEALTH CENTER

CONSENT FOR PHOTOGRAPHS

Patient_____ Place_____ Date_____

In connection with the medical services, which I am receiving from my physician, Dr. _____, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.

2. The photographs shall be taken by my physician or by a photographer approved by my physician.

3. The photographs shall be used for medical records and if in the judgement of my physician, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

Signed_____
(Patient) Date

Witness_____
Date