Colorado Center for Hyperbaric Medicine

Patient Information

PATIENT INFORMATION *(please print)*		Today's Date:
Full Name	Gender: M / F	E-mail Address:
Address		City State ZIP
Home Phone #		Alternate Phone # (Work/Cell)
Social Security #		Date of Birth Age

Emergency Contact Name	Relationship to Patient
Home Phone #	Alternate Phone # (Work/Cell)

Guarantor's Full Name Gender: M F	
Social Security #	Date of Birth Age
Address	City State ZIP
Home Phone #	Alternate Phone # (Work/Cell)
Marital Status: _ Single _ Married _ Widowed _ Divorced _ Separated	_ Child under 18: Father's Full Name: ________________________ Phone # _______________________ Mother's Full Name: _______________________ Phone # _______________________

Guarantor's Employer	
Address	City State ZIP
Phone #	Fax #

Primary Insurance Co. & Phone Number	**Secondary** Insurance Co. & Phone Number
AUTHORIZATION #	
Address	Address
Policy Holder	Policy Holder
Social Security #	Social Security #
Policy ID #	Policy ID #
Group ID #	Group ID #
Policy Holder's Relationship to Patient: _ self _ spouse _ parent _ other	Policy Holder's Relationship to Patient: _ self _ spouse _ parent _ other

PLEASE ALLOW US TO MAKE A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE CARD(S)

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Colorado Center for Hyperbaric Medicine

Patient History

Patient Name: ____

SS Number: ____

Date of Birth:____

	Yes	No	Date of onset	Description of problem
ALLERGIES				
Any history of allergies?				
Are you allergic to any medication?				
PULMONARY				
Any history of pulmonary problems?				
Pneumothorax				
Smoker				
COPD				
Asthma				
EARS, NOSE, AND SINUSES				
Any history of ear, nose, or sinus problems?				
Ear infections				
Hearing difficulty				Left___ Right___
Problems flying				
Ear surgery				
Myringotomy				
Nasal problems				
Nasal obstruction				
On antihistamines				
Septal problems				
Rhinitis				
Sinusitis				
Seasonal allergies				
Sinus infections				
CARDIAC				
Any history of cardiac problems?				
Pacemaker				
Heart attack				
Congestive heart failure				
Hypertension				
NEUROLOGICAL				
Any history of neurological problems?				
Brain injury				
Stroke				
Anoxia				
Optic neuritis				
Seizure disorder				
Other				
DIABETES				
Are you a diabetic?				
Medication/Insulin				
Blood sugar range				Range:
Frequency of sugar monitoring				Frequency:
Insulin reaction				Symptoms:
				Treatment:

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Patient History

Patient Name: ____________________________________

SS Number: _____________________________________

Date of Birth:_____________________________________

	Yes	No	Date of onset	Description of problem
G.I./G.U.				
Any history of G.I or G.U. problems?				
Frequent diarrhea				
Gas				
Incontinent stool				
Incontinent urine				
Constipation				
Ostomy				
EYES				
Any history of eye problems?				
Cataracts				
Surgery				
Retinopathy				
Last eye exam				
Glasses				`
Contacts				
PROSTHETICS				
Do you wear any prosthetic device?				Type:
Dentures				Upper__ Lower__ Partial__ Bridge __
Hearing aide				Left__ Right __
Breast implants				Type:
ADDITIONAL				
Have you ever been hit on the head or face?				
Have you ever had whiplash or a neck injury?				
Have you ever had a concussion?				
Have you ever been knocked unconscious?				
Are you pregnant?				
Are you claustrophobic?				
How do you best learn?				Reading __ Visual __ Verbal __
Are you on a nutritional program?				

COMMENTS (brief history):

MEDICATIONS:

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Authorization for Treatment

Patient Name: ______________________________________

SS Number: ____

Date of Birth:______________________________________

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical or medical procedure, or diagnostic test to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential side effects and risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request Colorado Center for Hyperbaric Medicine and such associates, technical assistants, and other health care providers as they may deem necessary, to be involved in the course of my treatment(s). I understand that Hyperbaric Oxygen Therapy and associated services (medical, surgical, and/or diagnostic procedures) are planned for me and I voluntarily consent to and authorize these procedures.

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as to result or cure. I realize that some indications for treatment with Hyperbaric Oxygen Therapy may be considered off-label or investigational by the FDA and the UHMS and may not be reimbursable by my insurance company.

I understand that there are possible side effects and risks related to the Hyperbaric Oxygen Therapy and associated services and/or diagnostic procedures planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for adverse reactions. I also realize that the following risks and hazards may occur in connection with these particular procedure(s):

____

I herby authorize any or all information regarding this procedure to be used in an effort of research, education, and publication by the Colorado Center for Hyperbaric Medicine. I understand that the Colorado Center for Hyperbaric Medicine agrees to maintain my complete anonymity in this matter.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment and incompletion of treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent and authorization for treatment.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

______________________________________ ______________________________________

Signature of Patient or Legally-Responsible Person Signature of Witness

______________________________________ ______________________________________

Printed Name *(and relationship, if parent or guardian)* Printed Name of Witness Date

____

Date

Colorado Center for Hyperbaric Medicine

HIPAA Notice

Patient Name: ______________________________

SS Number: ______________________________

Date of Birth: ______________________________

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact: Privacy Officer, Colorado Center for Hyperbaric Medicine

We are required by law to:

· maintain the privacy of protected health information,
· give you this notice of our legal duties and privacy practices regarding your health information, and
· follow the terms of the notice currently in effect.

How we may use and disclose your health information

Described as follows are the ways we may use and disclose your health information. Except for the following purposes, we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to: Privacy Officer, Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621

Treatment: We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations: We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services: We may use and disclose your health information to contact you and remind you of your appointment, or to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family members or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research: We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law: We will disclose your health information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates: We may disclose your health information to our business associates who perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans: If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military, we may release your health information to the foreign military command authority.

Worker's Compensation: We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose your health information for public health activities to prevent or control disease, injury, or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions, product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence, we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities authorized by law. These may

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include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons, or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death or other similar circumstance.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

Your Rights Regarding Your Health Information

Right to Inspect and Copy: You have the right to inspect and copy your medical and billing records by written request to Privacy Officer, , Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621

Right to Amend: You have the right to request an amendment to your records by written request to Privacy Officer, , Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621

Right to an Accounting of Disclosures: You have a right to an accounting of certain disclosures by written request to Privacy Officer, , Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621

Right to Request Restrictions: You have the right to request restriction or limitation on your health information used for treatment, payment, or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Privacy Officer, , Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and must be addressed to Privacy Officer, , Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621. We will accommodate reasonable requests.

Changes to This Notice

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Privacy Officer, Colorado Center for Hyperbaric Medicine, 1460 E. Valley Rd. Suite 104, Basalt, CO 81621.

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________________________________ ________________________________

Signature of Patient or Legally-Responsible Person Signature of Witness

________________________________ ________________________________

Printed Name *(and relationship)* Date Printed Name of Witness Date

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