Hyperbaric Services of the Palm Beach
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes B5, H3, H4, & I8
Delray Beach, FL 33484
561-819-6125
561-819-6127 – Fax

Patient Information

(Please Print)

Date: _____

Name: _____ S.S # _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Are you from out of town? Yes or No If Yes, your local address and phone number

_____

Circle Status: Minor Single Married Divorced Widowed Separated

If Minor, Parent or Legal Guardian:

_____

Spouse's Name:

_____

Home Phone: _____ Work/Cell Phone: _____

Person Responsible for the Bill:

_____

Address & Phone Number:

_____

Employer, Address & Phone Number:

_____

_____

Is this patient covered by insurance? Yes or No Please indicate primary insurance

MEDICARE HUMANA AVMED AENA BCBS NHP CIGNA WORKCOMP

OTHER: _____

Subscribers Name: _____ S.S # _____

Date of Birth: _____ Group #: _____ Policy # _____

Patient's Relationship to Subscriber: SELF SPROUSE CHILD OTHER: _____

Secondary Insurance (If Applicable) _____

Subscriber's Name: _____ Date of Birth: _____

Group #: _____ Policy #: _____

Patients Relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

IN CASE OF EMERGENCY: Name of Local Friend or Relative (not living at the same address): _____ Relationship: _____

Home/Work Phone: _____ Cell Phone: _____

(PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)

Physician Information

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hyperbaric Services of the Palm Beaches, LLC or insurance company to release any information required to process my claims.

_____

Patient/ Guardian Signature Date

EMAILUS AT: OXYGEN4U@BELLSOUTH.NET

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Patient Medical History

Patient Name: _____ Date: _____
Diagnosis: _____ Date of Birth: _____
Referring Doctor: _____ Phone: _____

Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Aids or HIV Infection	___	___	Glaucoma	___	___	Malignant Disease	___	___
Anemia	___	___	Hay Fever/Allergies	___	___	Mitral Value Prolapse	___	___
Angina	___	___	Hepatitis/Jaundice	___	___	Neurological Disease	___	___
Arthritis	___	___	Heart Attack	___	___	Radiation Therapy	___	___
Asthma	___	___	Heart Disease	___	___	Recent Weight oss	___	___
Bronchitis	___	___	Heart Murmur	___	___	Respiratory problems	___	___
Cancer	___	___	Heart Problems	___	___	Rheumatic Fever	___	___
Cardiac Pacemaker	___	___	Herpes	___	___	Rosacea	___	___
Chest Pains	___	___	High Blood Pressure	___	___	Seizure Disorders	___	___
Claustrophobia	___	___	Infections, Frequent	___	___	Stomach Problems	___	___
Cough - Chronic	___	___	JointReplacement/Implant	___	___	Stroke	___	___
Diabetes	___	___	Kidney Disease	___	___	Swollen Ankles	___	___
Ear Problems/Surgery	___	___	Liver Disease	___	___	Thoracic Surgery	___	___
Emphysema	___	___	Low Blood Pressure	___	___	Tuberculosis	___	___
Epilepsy/Convulsions	___	___	Lung Disease	___	___	Ulcer	___	___
Fainting/Seizures	___	___	Lung Infection, Frequent	___	___	Wounds	___	___
Frequently Tired	___	___	Lung, Shortness of Breath	___	___	Other	___	___

If yes, notes or comments: _____

_____

_____

List of surgical procedures (procedure and date): _____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in medical treatment. I authorize Hyperbaric Services of the Palm Beaches DBA International Institute for Brain Enhancement (IIBE), to use photographs of me in educational presentations. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (parent or guardian) Date

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Patient Name: _____ Date: _____

Date of Birth: _____

List of Current Medications: _____

_____

_____

_____

_____

List any Allergies to Medications: _____

_____

_____

_____

_____

_____

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RELEASE FOR RECORDS

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____

HOME PHONE: _____

DATE OF BIRTH: _____

I GIVE MY PERMISION TO RELEASE RECORDS TO:

Hyperbaric Services of the Palm Beaches
International Institute for Brain Enhancement
5130 Linton Blvd Suite B5, H3 & H4, I8
Delray Beach, FL 33484
561-819-6125
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☐ MEDICAL RECORDS ☐ RADIOLOGY STUDIES ☐ LAB TESTS ☐ EEGS ☐ TMS

☐ MANUFACTURE'S INFORMATION CARD FOR ANY IMPLANTED DEVICES

☐ OTHER:

_____

PATIENT SIGNATURE: _____

PATIENT PRINTED NAME: _____

WITNESS: _____ DATE: _____

Hyperbaric Services of the Palm Beaches, LLC

5130 Linton Blvd.

Suite H 3&4

Delray Beach, Fl 33484

561-819-6125

CANCELATION, LATENESS AND FEE AGREEMENT

Due to our tight scheduling and treatment plan for each patient we would appreciate being given 24 hour cancellation notice. If you are calling after office hours please leave a message with the answering service.

If you anticipate being late for your appointment please notify us as soon as possible so we can productively utilize the time slot. Also, note if you are more than ten minutes late for your schedule treatment this may result is a shorter treatment session.

Please note that too many no shows, cancellations or lateness may result in a fee and or and or the loss of your present schedule time slot.

I, _____, am the responsible party for payment to Hyperbaric Services of the Palm Beaches, LLC.

Date: _____

Hyperbaric Services of the Palm Beaches
International Institute for Brain Enhancement (IIBE)

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Delray Beach, FL 33484

General Consent for Hyperbaric Treatment and Liability Disclaimer

The patient hereby consents to treatment with hyperbaric oxygen therapy and related services provided by Hyperbaric Services of the Palm Beaches DBA IIBE. The patient acknowledges and understands that hyperbaric oxygen therapy for patient's condition is not purported to be a standard therapy or cure; it is to be considered a supportive therapy only. Hyperbaric Services of the Palm Beaches DBA IIBE does not make any other claims or benefits for the treatment of patient's condition.

The patient also understands that such treatment is not an exact science and that no guarantees have been made concerning the results or potential side effects of the proposed services. Further, Hyperbaric Services of the Palm Beaches DBA IIBE cannot control all possible risks to or interactions with patient's other medical care, treatment or procedures outside of the Hyperbaric Services of the Palm Beaches DBA IIBE facility.

Hyperbaric Services of the Palm Beaches DBA IIBE do not warrant or guarantee any results of the hyperbaric oxygen therapy, and HEREBY EXPRESSLY DISCLAIMS ANY LIABILITY WHATSOEVER FOR ANY unanticipated effects or results of the hyperbaric oxygen therapy services provided. In consideration for hyperbaric oxygen therapy services received, patient voluntarily and knowingly agrees to release, hold harmless, indemnify and forever discharge Hyperbaric Services of the Palm Beaches DBA IIBE, its affiliates and related entities, and their representatives, agents, employees, physicians, contractors, officers, directors, members, successors and assigns (collectively, "Released Entities"), from and against any and all liability, claims, suits, demands, or causes of action for any and all injury, or death arising out of or related to the hyperbaric oxygen therapy services, including payment of interest, and reasonable attorney's fees and costs.

My signature below represents that I am competent to execute this agreement, that I have read and understand the above, was given the opportunity to discuss this form and have any questions answered, and knowingly consent to the conditions set forth above.

Patient: _____ Date: _____
(PRINTED NAME)

_____
(PATIENT SIGNATURE)

Witness: _____ Date: _____

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Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Hyperbaric Services of the Palm Beaches DBA IIBE, may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operation (TPO). Please refer to our notice of Privacy Practices for a more complete description of such disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, Hyperbaric Services of the Palm Beaches DBA IIBE, may call your home or office and leave a message in reference to any items that assist the practice of carrying out TPO such as appointment reminders, insurance items and any calls pertaining to your clinical care.

With your consent, Hyperbaric Services of the Palm Beaches DBA IIBE, may mail to your home or office any items that assist the practice of carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. IF YOU DECLINE TO SIGN THIS CONSENT, WE MAY DECLINE TREATMENT TO YOU.

Patient's Name _____

Signature of Patient or Legal Guardian _____

Print Name of Patient or Legal Guardian _____

Date _____

HIPAA Notice of Privacy Practices
Hyperbaric Services of the Palm Beach
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes B5, H3, H4, & I8
Delray Beach, FL 33484

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about, including demographics information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you be name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement:
Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security:
Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

INITIAL_____

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure of indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us be alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes enactive on or before April 14, 2003. We are required by Law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

INITIAL _____

Authorization for Release of Information

Patient Name: _____ DOB: _____

_____ , is authorized to release protected health information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you Approve to receive information	**Description of Information to be released** Check each that can be given to person or entity on the left in the same section
__ Voice mail/cell phone	__ results of lab tests/x-rays __ Other
__ Spouse(provide name/phone number)	__ financial __ medical
_____	
__ Parent (provide name/phone number)	___ financial ___ medical
_____	
___ Friend (provide name/phone number)	___ financial
	___ medical
_____	

I understand that I have the right to revoke this authorization at any time. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of patient or personal representative Date

Hyperbaric Services of the Palm Beaches, LLC
5130 Linton Blvd Suite 3 & 4
Delray Beach, FL 33484
561-819-6125

Dear Patient and Family,

We look forward to you starting your treatments at our facility. There are several safety measures that will be followed. Each patient must wear 100% cotton into the chamber, no buttons, snaps, Velcro and/or iron ons are not allowed. If you do not have clothing that is 100% cotton the facility will supply you with them during your treatment. A disposable diaper may be worn but must be covered by cotton pants or shorts.

Anyone going into the chamber for treatment must not have on:

Ointments	Hairspray
Hair Accessories	Deodorant
Dentures	Perfume
Hearing Aides	Mousse
Nail Polish	Hair Gel
Contact Lenses	Make Up
Jewelry	Lotions

NO toys, books or magazines are allowed in the chamber. A pacifier or clear bottle is allowed.

Due to the HIPPA Privacy Act we are unable to allow family members to stay in the hyperbaric room while the patient is being treated.

Patients should not drink any carbonated drinks at least one hour, if not more, prior to treatment, as it may cause stomach upset. A well balanced meal prior to your treatment is recommended, with the exception of patients with all types of feeding tubes, they must be fed no less than two hours before treatment time. Flying is not recommended 24 hours pre and post treatment. If the patient has a temperature of 101 degrees or higher they will not be treated.

Our patient safety, comfort, and privacy are this facility's top priority.

I have read the above statements and agree to abide by them.

Name: _____

Date: _____

Hyperbaric Services of the Palm Beaches

Initial Learning Assessment

Name: _____

Date: _____

During your visit with our organization you will be presented with information that may be new to you. To aid in providing the best care possible please answer the following questions.

How do you like to learn new things? Please check all that apply.

	Reading		Pictures/Diagrams
	Discussion		Hands On/Demonstration
	Videotapes		Self-Study

Factors that can affect learning:	Yes	No	Comments
Do you speak English in your home?			If no what languages do you speak? Name of Interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? Yes No
Do you see well?			If no, do you utilize glasses or contact? Yes No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If yes explain

Other Comments:

_____

_____