HYPERBARIC MEDICINE HEALS.

PATIENT DEMOGRAPHIC INFORMATION

PLEASE PRINT

Last Name	**First Name**	**MI**
Social Security Number	**Date of Birth**	
Address		
City	**State**	**Zip**
Home Phone	I authorize HyOx Medical Treatment Center to leave a detailed voicemail message regarding my personal health information. ☐ **YES** ☐ **NO**	
Cell Phone	I authorize HyOx Medical Treatment Center to leave a detailed voicemail message regarding my personal health information. ☐ **YES** ☐ **NO**	
Email Address		
Employer	**Work Phone**	
Gender ☐ **Male** ☐ **Female** ☐ **Transgender MTF** ☐ **Transgender FTM** ☐ **Genderqueer** ☐ **Other**		
Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Legally Separated**		
Race ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Latino** ☐ **Multiracial** ☐ **Native American** ☐ **Other**		
Ethnicity ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Not Reported/Refused**		

EMERGENCY CONTACT INFORMATION:

Name (first and last)	Relationship	Phone

PARENT / LEGAL GUARDIAN / POA / RESPONSIBLE PARTY (if applicable):

Name (first and last)	Relationship	Phone

CURRENT PHYSICIANS: **Please list ALL of your current physicians (first and last name) and their contact information.**

Physician Name	Specialty	Phone & Office Location

Patient's Signature **Date**

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CURRENT MEDICATIONS

NAME **DATE OF BIRTH**

PHARMACY **DATE**

PHARMACY PHONE NUMBER

Please list current medications <u>including</u> over-the-counter medications, vitamins and supplements, if applicable:

MEDICATION NAME	DOSAGE (example: 50 mg)	FREQUENCY (example: once daily)	Date to be Completed

ALLERGIES: **Please check the appropriate box(es) and provide additional information if applicable.**

☐ None ☐ Sulfa ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Other (*please list below*)		

HYPERBARIC MEDICINE HEALS.

CONSENT TO SPEAK

I, _____, authorize Dr. Richard W. King, Jr., Dr. Marianne Taryla and the clinical staff at HyOx Medical Treatment Center to discuss information related to my medical care with the following family members/caretakers:

NAME	RELATIONSHIP	PHONE

This authorization will not expire unless revoked by you or your legal representative or upon notification of death.

Patient's Signature **Date**

Witness Signature **Date**

LIVING WILL / ADVANCED DIRECTIVES

I understand that Hyperbaric Oxygen Therapy has certain risks which the physician and clinical staff have described in depth. I have had all my medical questions answered.

If I have a Living Will and/or Advance Directive(s), I agree to provide a copy to HyOx prior to my first treatment. If I do not provide this document, I agree to hold HyOx and its medical staff harmless if CPR or other life sustaining procedures are provided.

(please initial one) _____ I **have** a living will or advanced directive.

_____ I **do NOT have** a living will or advanced directive**.**

Printed Name **DOB**

Patient's Signature **Date**

Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

HYPERBARIC MEDICINE HEALS.

PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING PRIVACY PRACTICES

I understand that the patient's health information is private and confidential. I understand that HyOx Medical Treatment Center, Inc. (HyOx), Richard W. King, Jr., MD (Dr. King) and Marianne Taryla, MD (Dr. Taryla) in conjunction with the staff and other intermittent physicians, work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that HyOx and Drs. King and Taryla may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

HyOx, Dr. King and Dr. Taryla have a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

HyOx, Dr. King and Dr. Taryla may update this Acknowledgment and "Notice of Privacy Practices". If I ask, HyOx, Dr. King and/or Dr. Taryla will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods or alternative location.

HyOx and Drs. King and Taryla have established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist HyOx and Drs. King and Taryla by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of HyOx and Dr. King's and Dr. Taryla's "Notice of Privacy Practices".

Printed Name	**DOB**
Patient's Signature	**Date**
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)	

HYPERBARIC MEDICINE HEALS.

INFORMED CONSENT FOR PHOTOGRAPHY

In connection with the medical services which I am receiving from HyOx Medical Treatment Center, Inc. (HyOx), Richard W. King, Jr., MD (Dr. King) and Marianne Taryla, MD (Dr. Taryla) and other intermittent physicians, I consent that pictures may be taken of me or my body, under the following conditions:

(1) The photographs may be taken only with the consent of my physician and at such time as may be approved by him/her.

(2) The photographs shall become part of my medical record. I understand that the medical records, including photographs, may be released to other physicians involved with my care and/or representatives from my health plan such as case managers and medical directors.

(3) If in the judgment of my physician, medical research, education or science will be benefited by their use, such pictures and information relating to my care may be published either separately or in connection with each other, in professional journals, case studies or medical books or transmitted by television or other device for viewing 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 and that my anonymity will be preserved.

Printed Name **DOB**

Patient's Signature **Date**

Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

AUTHORIZATION TO TREAT

I consent to examination, treatment, and procedures which may be performed during my office visits including emergency treatment considered necessary by the physician and/or designated provider.

Printed Name **DOB**

Patient's Signature **Date**

Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

HYPERBARIC MEDICINE HEALS.

FINANCIAL POLICY

Thank you for choosing HyOx Medical Treatment Center as your health care provider. We will do our best to meet your expectations and to offer you the best care possible. As there is often confusion concerning health insurance and managed care, we feel it is necessary to explain some of our financial policies.

We participate with many insurance companies that offer custom designed health plans. Each plan can differ in the benefits it provides and the services it covers. For that reason, while we do our best, it is impossible for us to thoroughly examine each individual plan. That responsibility is yours. If you have any questions, contact your insurance company for clarification. We will do everything we can to assist you in obtaining the benefits that you are entitled to, but, ultimately, you are responsible for the payment of charges associated with services you receive.

We will accept assignment of insurance, not inclusive of any deductibles or coinsurance. Payment arrangements can be made on an individual basis. These charges will be your responsibility. If we receive payment from the insurance company after you have paid, we will issue you a refund.

If you believe you may need alternative payment arrangements, please ask to speak with our Patient Account Representative **before** services are rendered. Please note that failure to pay or make arrangements in a timely manner may result in additional interest, collection, and/or attorney fees.

Summary:

- Familiarize yourself with your particular insurance plan, coverage and benefits.
- Understand that if you fail to follow them, you become responsible for charges they deny.
- Always carry your insurance card with you, and present it when you receive services.
- Be prepared to pay all co-payments, deductibles, and non-covered services at the time of service.
    - For your convenience, we accept exact cash, checks, Visa, MasterCard, American Express, and Discover.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical and/or surgical benefits to HyOx Medical Treatment Center, Inc. and Richard W. King, Jr., MD, including Medicare, Medicaid, private and commercial insurance, and any other health plans.

I further authorize HyOx Medical Treatment Center, Inc., and Richard W. King, Jr., MD to release to Medicare and its agents, my insurance company, or my health plan any information needed to determine benefits payable to related services.

I certify that I have read and agree to the financial policy and the assignment of benefits as stated above and that all questions concerning the above policy have been answered to my satisfaction. I understand insurance will be filed as a courtesy to me; however, I am financially responsible for my account and any charges not covered by insurance.

Printed Name	**DOB**
Patient's Signature	**Date**
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)	
Guarantor (if not self)	**Guarantor DOB**

HYPERBARIC MEDICINE HEALS.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release my medical records to:

HyOx Medical Treatment Center
Richard W. King, Jr., M.D.
Marianne Taryla, M.D.

2550 Windy Hill Road
Suite 110
Marietta, GA 30067
Phone: 678.303.3200
Fax: 678.303.3205

Printed Name **DOB**

Patient's Signature **Date**

Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)