HYPERBARIC AND REHABILITATIVE MEDICINE

PATIENT INFORMATION

PLEASE PRINT

PATIENT DEMOGRAPHIC INFORMATION:

Last Name	**First Name**	**MI**
Address		
City	**State**	**Zip**
Social Security Number	**Date of Birth**	
Home Phone	**Cell Phone**	
Employer	**Work Phone**	
Sex: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Not Reported/Refused		
Race: ☐ Asian ☐ African American ☐ Caucasian ☐ Latino ☐ Multiracial ☐ Native American Indian ☐ Other		
Spouse's name (if applicable)	**Spouse's Phone**	
Guarantor	**Guarantor DOB**	
Email Address		

EMERGENCY CONTACT INFORMATION:

Name (first and last)	Relationship	Phone

CURRENT PHYSICIANS: Please list your current and referral physicians (first and last name) and their contact information

Physician Name	Specialty	Phone

___ I authorize HyOx Medical Treatment Center to leave a detailed voicemail message regarding my personal health information on the following phone number: _____

___ I *DO NOT* authorize HyOx Medical Treatment Center to leave any detailed voicemail messages.

_____

Patient or legally authorized signature **Date**

Rev. 07/26/18

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CURRENT MEDICATIONS

PATIENT: _____ **DATE OF BIRTH:** _____

PHARMACY: _____ **PHONE NUMBER:** _____

Please list current medications including 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*)

PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING PRIVACY PRACTICES

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

PREVIOUS NAME: _____

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) work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that HyOx, Dr. King and Dr. 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. These situations are very unusual. One example would be if a patient threatened to hurt someone.

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 and is attached to this Acknowledgment. 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 and Drs. King and 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 aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications 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".

Patient's or legally authorized individual's signature: _____

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

Date: _____

HyOx Medical Treatment Center, Inc.
Richard W. King, Jr., MD

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

500 Medical Center Blvd.
Suite 170
Lawrenceville, GA 30245

www.hyox.com

HYOX
HYPERBARIC AND REHABILITATIVE MEDICINE

INFORMED CONSENT FOR PHOTOGRAPHY

In connection with the medical services which I am receiving from HyOx and from my physicians, Dr. Richard W. King, Jr. and/or Dr. Marianne Taryla, 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.

(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.

Patient's or legally authorized individual's signature: _____

***Name** (please print):* _____

Date of Birth: _____

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 his designated provider.

Patient's signature: _____

***Name** (please print):* _____ DOB: _____

Date: _____

HYPERBARIC AND REHABILITATIVE MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release my medical records to:

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

☐ 2550 Windy Hill Rd.,Suite 110
Marietta, GA 30062
Phone: 678.303.3200
Fax: 678.303.3205

☐ 500 Medical Center Blvd, Suite 170
Lawrenceville, GA 30046
Phone: 678.672.1640
Fax: 678.672.1647

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____