forward HEALTH SOLUTIONS, PLLC

NEW PATIENT INFORMATION
Hyperbaric Oxygen Therapy

CONTINUE ONLY IF:
Not currently prescribed or taking medications: Bleomycin, Disulfiram, Mafernide Acetate

Do not have or suspect having: Hereditary Sperocytosis, Sickle Cell Anemia, COPD

Date: _____

Name: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Minor, Parent or Legal Guardian:

Spouse's Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

What is Your Primary Reason for Coming to Forward Health Solutions?

_____

_____

Who May We Thank for Referring You? _____

Physician Information

☐ Yes ☐ No Are You Currently Under a Doctor's Care?

Physician's Name: _____

Address: _____

City: _____ State: _____ Phone: _____

Patient Medical History

Yes No

☐ ☐ Are you under medical treatment now?

☐ ☐ Do you exercise on a regular basis?

If so, how often? _____

☐ ☐ Do you use tobacco?

☐ ☐ Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?

If yes, please explain:

_____

_____

_____

_____

Yes No

☐ ☐ Do you use alcohol?

If so, how often? _____

☐ ☐ Are you pregnant or think you may be pregnant?

If so, how many weeks? _____

If no, what was the date of your last menstrual period? _____

☐ ☐ Are you taking medication(s)?

If yes, what medication(s) are you taking?

_____

_____

_____

List any medications you are allergic to: _____

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

Yes	No		Yes	No		Yes	No	
☐	☐	Acute Respiratory Illness	☐	☐	Frequent Ear Infections	☐	☐	Mitral Valve Prolapse
☐	☐	AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	Neurological Disease
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Radiation Therapy
☐	☐	Angina	☐	☐	Hay Fever / Allergies			If YES, When? _____
☐	☐	Anxiety	☐	☐	Hepatitis / Jaundice	☐	☐	Recent Weight Loss
☐	☐	Arthritis	☐	☐	Heart Attack	☐	☐	Respiratory Problems
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever
☐	☐	Back Pain	☐	☐	Heart Murmur	☐	☐	Ringing in the Ears
☐	☐	Cancer	☐	☐	Heart Problems	☐	☐	Rosacea
☐	☐	Chemical Sensitivity	☐	☐	Herpes	☐	☐	Seizure Disorders
☐	☐	Chest Pains	☐	☐	High Blood Pressure	☐	☐	Stomach Problems/Ulcers
☐	☐	Chronic Bronchitis	☐	☐	Infections, Frequent	☐	☐	Stroke
☐	☐	Chronic Fatigue (CFS)	☐	☐	Kidney Disease	☐	☐	Swollen Ankles
☐	☐	Claustrophobia	☐	☐	Leukemia	☐	☐	Thyroid Problems
☐	☐	Diabetes – Insulin Dependent	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Emphysema	☐	☐	Low Blood Pressure	☐	☐	Other
☐	☐	Fainting / Seizures	☐	☐	Lung Disease			_____
☐	☐	Fever Related Seizures	☐	☐	Lung Infection, Frequent			_____
☐	☐	Fibromyalgia	☐	☐	Malignant Disease			_____

☐ Yes ☐ No Have you ever had any ear problems?

☐ Yes ☐ No Do you have any problems with your ears when you fly?

☐ Yes ☐ No Do you have any problems going up and down in an elevator?

☐ Yes ☐ No Do you have back problems?

Patient Comments:

I certify that I have read and understood 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 my medical treatment. I understand it is my responsibility to update this information as needed. This includes changes in medical condition/diagnosis, medications, as well as personal and physician contact information. I agree to be responsible for payment of all services rendered on my or my dependents behalf.

Signature of patient (parent or guardian)

Provider's Comments:

Hyperbaric Oxygen Therapy Consent Form

Patient Name: _____ DOB: _____

CONTINUE ONLY IF:

- *You are **not** currently prescribed or taking these medications:*
  - *Bleomycin, Disulfiram, Mafernide Acetate*
- *You do **not** have or suspect having:*
  - *Hereditary Spherocytosis, Sickle Cell Anemia, COPD*

The technology, known as Hyperbaric Oxygen Therapy (HBOT), has been reported to have beneficial effects for a wide range of conditions, without negative side effects. Nevertheless, as with many treatments, there are areas of concern which you should be aware. It is important that you take a few minutes to read the following information.

OTIC BAROTRAUMA*: Is a condition of injury to the eardrum, and is extremely unlikely to occur in the Hyperbaric chamber. However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized and depressurized you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You will most likely experience "popping" in your ears. This is normal. You can assist the equalization process by yawning, chewing, swallowing, working your jaw side to side and up and down, turning the head side to side and ear to shoulder. Sitting upright in the chamber during pressurization and depressurization will generally also make the equalization process more comfortable. In general, doing whatever assists you being comfortable when taking off and landing in a plane may be most effective for you. Continue to do this as needed for the duration of pressurization and depressurization. When the chamber reaches full pressure and again when the chamber is completely deflated there should be no additional pressure in the ears**. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF.** *This will give us the opportunity to make adjustments in the pressurization or depressurization process to eliminate discomfort. If you are unable to equalize the pressure in your ears the visit will be immediately terminated. If this happens or if pain persists beyond the visit, we recommend that you consult your physician to evaluate and alleviate the situation before attempting another visit.*

EAR, SINUS AND/OR THROAT CONGESTION, HEAD COLDS, VIRUS OR PRIOR TRAUMA TO THE EARS*: You may consider rescheduling your visit in the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent but may occur**. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF** *so we can assist you or terminate your visit**. We recommend you consult your physician in order to alleviate the underlying condition before attempting another visit.*

PULMONARY HYPEREXPANSION*: This condition is very rare under Hyperbaric treatments. However, to be overly cautious, **HOLDING YOUR BREATH DURING DECOMPRESSION MUST BE AVOIDED** as it could lead to expansion of the air in your lungs and damage to the lung tissues. In the highly unlikely event of an unexpected rapid decompression, it is critical that you exhale immediately.*

MEDICATIONS*: Hyperbaric Therapy may enhance the effectiveness or increase the metabolism (decrease the effectiveness) of any medication you are taking. **IT IS RECOMMENDED THAT YOU HAVE THE DOSAGE AND FREQUENCY OF ALL MEDICATIONS MONITORED AND ADJUSTED REGULARLY BY YOUR PHYSICIAN**.*
PREGNANCY*: **HYPERBARIC THERAPY IS NOT ALLOWED DURING THE FIRST TRIMESTER.** After this time it may be beneficial to both mother and child. **INITIALS** _____*

SEIZURES*: Hyperbaric Therapy is not associated with causing or inducing seizures. **IF ANYONE GETTING IN THE CHAMBER IS SEIZURE PRONE, THE STAFF MUST BE MADE AWARE PRIOR TO THE FIRST VISIT.** If a seizure is experienced in our clinic, unless otherwise instructed (and a waiver is signed), our procedure is to call 911, remove the patient from the chamber and make the individual as comfortable as possible.*

DETOXIFYING OR CELL DIEOFF*: Hyperbaric Therapy may assist the body to naturally detoxify and balance digestive flora. **AN INDIVIDUAL MAY EXPERIENCE SOME DISCOMFORT FROM THIS PROCESS IN AS LITTLE AS 1 TO 36 HOURS AFTER TREATMENT**. Symptoms may include; flu like symptoms, loss of appetite, stomach ache, constipation, diarrhea, headache, behavioral issues etc.*

Although unpleasant, this is a natural process and continuing treatments may be of benefit to more rapidly accomplish a positive result. However ***IF SYMPTOMS PERSIST, WE RECOMMEND CONSULTING YOUR PHYSICIAN TO EVALUATE AND ALLEVIATE THE SITUATION BEFORE ATTEMPTING ANOTHER VISIT****.*

PNEUMOTHORAX*: Hyperbaric Therapy is contraindicated for an existing pneumothorax (collapsed lung).* ***IF YOU HAVE A PNEUMOTHORAX OR SUSPECT THAT A PNEUMOTHORAX IS AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.*** *If you have experienced a pneumothorax in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with Hyperbaric Therapy.*

COMPRESSIVE BRAIN LESIONS – SUBDURAL HEMATOMA, INTERCRANIAL HEMATOMA*: Hyperbaric Therapy is contraindicated for existing compressive brain lesions (subdural hematoma, intercranial hematoma).* ***IF YOU HAVE COMPRESSIVE BRAIN LESIONS OR SUSPECT THAT COMPRESSIVE BRAIN LESIONS ARE AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.*** *If you have experienced compressive brain lesions in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with Hyperbaric Therapy.*

DIABETES / INSULIN DEPENDANT*: Insulin dependency may result in a drop in blood sugar while in the chamber.* ***IT IS CRITICAL THAT YOU IMMEDIATELY COMMUNICATE TO THE STAFF IF YOU EXPERIENCE OR ANTICIPATE AN EPISODE. YOUR TREATMENT WILL BE TERMINATED.*** *You are required to; A) take a blood sugar reading prior to your treatment (if below 150, you must have a snack prior to treatment) and again after your treatment (if below 150, you must have a snack prior to leaving). B) Take a protein bar and a juice box (or whatever you use if faced with a "drop" in the normal management of your condition) into the chamber with you.*

SENSITIVITY TO CHEMICALS (MCS) / ODORS / ALLERGY*: Avoid wearing heavy colognes as the smells may linger in the chamber and have an adverse effect on another patient****. IF YOU EXPERIENCE ADVERSE SENSITIVITY OR HAVE ALLERGIES THAT MAY BECOME AGGRAVATED WHILE IN THE CHAMBER, LET THE STAFF KNOW PRIOR TO YOU VISIT OR AS SOON AS POSSIBLE WHEN IN THE CHAMBER SO MEASURES CAN BE TAKEN TO ASSURE YOUR COMFORT OR IF YOUR VISIT NEEDS TO BE TERMINATED.*** *We recommend that you wear a charcoal mask or filter if it is known to assist your condition. If these sensitivities persist and you cannot exist comfortably in the chamber, you will need to consult your physician in order to alleviate the underlying condition before attempting another visit.*

I have read and fully understand the above information.

Signature: _____ **Date:** _____

PRIVATE LICENSE

The undersigned hereby grants a Private License to Forward Health Solutions, PLLC to provide Hyperbaric therapy to the undersigned. The undersigned acknowledges that Forward Health Solutions does not claim to prevent, nor cure any condition by use of hyperbaric medicine.

The undersigned acknowledges giving Informed Consent for HBOT. The undersigned hereby releases Forward Health Solutions from all claims and liabilities arising from the use or misuse of hyperbaric therapy indemnifying and holding Forward Health Solutions harmless from all claims and liabilities wherefrom, whatsoever.

In the unlikely event that the client has a dispute with Forward Health Solutions, the client agrees that the dispute shall be settled by arbitration.

I (print name) _____ have read, fully understand and consent to treatments in the Hyperbaric chamber.

Although Hyperbaric therapy has been reported to be beneficial for a wide range of conditions, this therapy is not meant as a cure for any condition or disease and no therapeutic outcomes can be guaranteed. We do not in any way recommend hyperbaric therapy as a substitute for any medical treatments prescribed or suggested by any medical physician. We do not make any guarantees to any results that an individual may experience. We do not accept insurance for our services.

Signature: _____ **Date:** _____

HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES FORWARD HEALTH SOLUTIONS TO USE AND / OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Forward Health Solutions to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related information, treatment alternatives, or other health related information.
Initial _____

I give permission to Forward Health Solutions to leave a phone message on my answering machine or voice mail.
Initial _____

I give Forward Health Solutions permission to provide hyperbaric therapy in an open room where other patients are also receiving hyperbaric therapy. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak privately with the doctor at any time, the doctor will provide a room for these conversations.
Initial _____

Signature: _____ **Date:** _____

Provider's Comments:

HIPAA NOTICE OF PRIVACY PRACTICE

FORWARD HEALTH SOLUTIONS, PLLC

General: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), set rules that regulate how a person's personal health information can be disclosed to others.

Protected Health Information: This includes oral or recorded information created or received by the healthcare provider, health plan, employers, or others concerning physical or mental health provisions or payment for healthcare.

How your medical information will be used and disclosed: We will use your protected health information as part of patient care. For example, your protected health information may be used by the healthcare professional treating you, by the business office processing your payment for services rendered, or by our staff reviewing the quality and appropriateness of the care received.

We may also use and/or disclose your medical information:

- when required to determine our compliance with relevant laws;
- for public health concerns, such as reportable infections, diseases and injuries.
- in the course of certain judicial or administrative proceedings;
- for law enforcement purposes and /or other specialized governmental functions;
- to a coroner, medical examiner, or funeral director.
- to prevent or lessen a *serious* threat to the health and safety of yourself and others;
- as authorized by laws related to Workers Compensation programs;
- to another provider to whom we refer you to for further care;
- to family members or any other person you specify here:
  _____ (please print) and initial _____

Your rights regarding your protected personally identifiable information include:

- the right to request restrictions on certain uses and disclosures;
- the right to receive communication from us in a confidential manner;
- the right to inspect and copy your medical information;
- the right to request an amendment to your medical information;
- the right to receive an accounting of the disclosures for up to six years prior to your request;
- the right to request a copy of this notice;
- the right to complain to Forward Health Solutions, PLLC and the U.S. Department of Health Human Services.

Disclaimer: Forward Health Solutions, PLLC strives to respect and maintain our patients' privacy. A new law with legal terms and unmanageable expectations will not suddenly make any healthcare facility perfect. We will continue to make every effort to provide the best quality healthcare to you and your family in a manner that protects your privacy. Further, we will never intentionally breach your confidence by disclosing **private** information without your consent. However, if you feel you have **serious** privacy issues or concerns, you may want to consider using another facility. It is impossible to soundproof our office or guarantee that someone will not overhear a conversation, see your name somewhere, or even meet you in our lobby.

Please speak with any staff member if you have any questions regarding this policy. If you feel your privacy rights have been violated, please contact our Privacy Officer: Joanne Barthel, Forward Health Solutions, PLLC, 140 Mayfair Road, Suite 1500, Hattiesburg, MS 39402, (601) 450-2077

Patient Name (Print): _____ Patient Signature _____ Date _____

Witness _____ Date _____

forward
HEALTH SOLUTIONS, PLLC

OFFICE POLICY

Patient Name: _____ DOB _____

PLEASE INITIAL EACH ITEM BELOW

___ **Primary Care and Emergencies**

- We do not assume treatment of chronic medical illnesses or general medical care (including pap smears, mammograms, and digital rectal exams).
- We do not prescribe refills of your routine medication prescribed by other physicians.

___ **Lab Work**

- We offer lab work at a significantly-reduced cost compared to many outside clinics. If you choose to have us do your lab work, allow 5-7 business days prior to your appointment. Payment is due at the time your blood is drawn.
- If you choose to obtain your lab work from an outside lab**,** you agree that you will have your blood draw 10-12 business days prior to your appointment. If you have an appointment and we do not receive all your labs or you do not bring the labs in with you, may need to schedule an additional appointment to review the labs we did not receive.

___ **Payment**

- **Agreement to Pay**: I understand and agree that I am responsible for payment of my account ***at the time of service,*** including my appointment and any services or supplements provided to me.
- We accept cash, personal checks, debit cards, VISA and MasterCard. Should your check be returned for non-sufficient funds, you will be charged $25 charge NSF fee and you will need to pay with cash or a credit card. Patients are responsible for all costs associated with collections on their accounts.
- **Insurance Patients**: We ***DO NOT*** accept any insurance, nor do we submit claims for you. We would be happy to provide you with an itemized invoice you may submit them to your insurance company. Note: Not all insurance companies will reimburse you for our services.
- **Medicare Patients:** ***We are an opt-out provider and you cannot bill Medicare*** for your visits or services provided by Forward Health Solutions.

___ **Appointment No-Shows, Cancellation and Late Fees**

- Appointments: Your appointment time is scheduled just for you. We do not double or overbook other patients into your appointment time. ***I also agree that if I do not cancel my appointment 24 hours prior to my appointment time, or on Friday morning prior to my Monday appointment time, I will be charged $100 for the missed appointment.***
- Late Fees: If you will be unavoidably late for your appointment, please let us know. If you arrive more than 15 minutes late, you may be required to reschedule.

___ **Medication Refills**

- Prescription refills should be requested at appointments, whenever possible.
- Refill requests should be made at least 2 business days prior to taking your last dose.

___ **Confidentiality**

- Your medical information is strictly confidential. We will not release it to anyone, including family members, without your written consent. However, if you wish, a family member may accompany you to your appointments without a written consent.
- If you want a copy of your records sent to another physician, we will require a written authorization from you.

___ **Employee Work Environment**

- Forward Health Solutions is committed to providing a work environment for our employees that is free of harassment of any nature, including sexual harassment or harassment based on such factors as race, color, religion, national origin, age, sex, marital status, and disability. Any patient who harasses a staff member or any other patients will be dismissed as a patient.

By signing this form, I acknowledge that I have read and agree to abide by the above office policy. I also understand that if I abuse or do not follow these policies, I may be discharged from the clinic.

Patient Name (Print): _____ Patient Signature _____ Date _____

Witness _____ Date _____

Rev. 4-8-15

forward
HEALTH SOLUTIONS, PLLC

Medicare Private Contract

This agreement is between Rebecca Boyd, D.O., and Tomia Carter, CFNP, whose principal place of business is 140 Mayfair Road, Suite 1500, Hattiesburg, Mississippi 39402

and

Beneficiary: _____ DOB: _____

Who resides at: _____

And is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective October 1, 2010. The physician is not excluded from participating in Medicare Part B under (1128) 1128, (1156) 1156, or (1892) 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following by placing initials before each statement:

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charges for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from the physician and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and other supplements plans may elect not to , make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been available to him.

Date: _____ By:_____Beneficiary or his/her legal representative

140 Mayfair Drive Suite 1500 ▪ Hattiesburg, MS 39402
601-450-2077 Office ▪ 601-450-2079 Fax