HYPERBARIC MEDICAL SERVICES
Wound Care & Dive Medicine

Your Partners In Healing

HYPERBARIC CONSULTANTS MEDICAL GROUP

INTAKE DATABASE

Please Print Legibly

Date: _____ Date of Birth: _____

Patient Name First: _____ MI:____ Last: _____Race: _____

What is your current gender identity? *(Check ALL that apply)*

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer

☐ Additional category (please specify): _____ ☐ Decline to answer

What sex were you assigned at birth? *(Check one)* ☐ Male ☐ Female ☐ Other ☐ Decline to answer

Referring Physician: _____Phone #: _____

Primary Physician: _____Phone #: _____

Other Physicians: _____

REQUIRED

Pharmacy: _____ **Phone #:** _____

Address / Street: _____

Home Health Agency: _____

ALL MEDICATION

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

DRUG ALLERGIES

MEDICATIONS	Adverse Effect

YOUR MEDICAL DIAGNOSES

ALL CURRENT OR PAST MEDICAL PROBLEMS

Approx. Date		Approx. Date	

ALL PREVIOUS SURGERIES, OPERATIONS

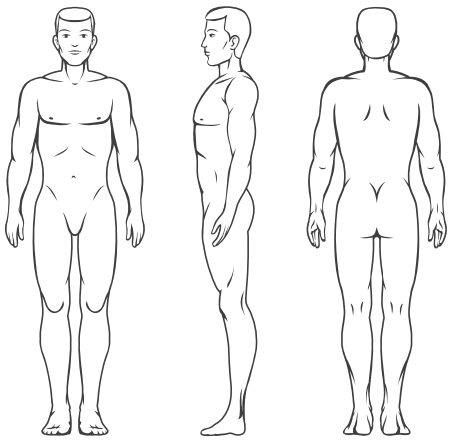
What is the location of your pain? _____

_____

Rate your pain (on a scale of 1-10):

Current	1	2	3	4	5	6	7	8	9	10
Worse	1	2	3	4	5	6	7	8	9	10
Best	1	2	3	4	5	6	7	8	9	10
Acceptable	1	2	3	4	5	6	7	8	9	10

Mark (X) the area that you are having pain.



How would you describe your pain? ☐ Intermittent ☐ Occasional ☐ Continuous

How long have you had this pain? _____

What is the quality of your pain?
☐ Ache ☐ Cramping ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing

What causes an increase in your pain, List all? _____ _____ _____

_____ _____ _____ _____

What relieves your pain? ☐ Medication ☐ Heat ☐ Relaxation ☐ Elevation ☐ Exercise ☐ Cold ☐ Nothing

What parts of your life are affected by pain? ☐ Sleep ☐ Quality of life ☐ Appetite ☐ Emotions ☐ Concentration ☐ Relationship

What is your current pain management plan? _____

_____

What are your goals for pain management? _____

_____

FAMILY AND SOCIAL HISTORY

What is your marital status? ☐ Married ☐ Single ☐ Widow ☐ Widower ☐ Separated ☐ Divorced ☐ Significant other

What is your current living situation? ☐ With family ☐ Alone ☐ SNF (skilled nursing facility) ☐ Assisted living ☐ Other

Do you have a family member or friend that can assist in your care? ☐ Yes ☐ No

What is/was your primary career? _____

Are you Retired? ☐ Yes ☐ No

If yes why did you retire? _____

_____

How would you describe your current activity level? ☐ Active ☐ Sedentary ☐ Minimal ☐ Restricted

Have you ever smoked? ☐ Yes ☐ No How many packs of cigarettes do you smoke a day? _____

What year did you start smoking? _____ What year did you stop smoking? _____

How long does it take you to drink a six pack of beer, fifth of liquor, or bottle of wine?
☐ Do not drink ☐ Unknown ☐ A day ☐ A week ☐ A month ☐ 6 months ☐ A year

What recreational drugs do you use? (check all that apply)
☐ None ☐ Marijuana ☐ Methamphetamine ☐ Cocaine ☐ Heroin ☐ LSD ☐ Other _____

Has your mother passed away? ☐ Yes ☐ No

If yes what was the cause of death of your Mother? _____

Has your father passed away? ☐ Yes ☐ No

If yes what was the cause of death of your Father? _____

Are there any other pertinent diseases that run in your family? _____ _____

_____ _____ _____ _____

Patient Name: _____ DOB _____

REVIEW OF SYSTEMS

CONSTITUTIONAL								
Appetite Change	Y☐	N☐	Intended Weight Loss	Y☐	N☐	Pain	Y☐	N☐
Chills	Y☐	N☐	Lethargy (Decreased Level Of Alertness)	Y☐	N☐	Unintended Weight Gain	Y☐	N☐
Fever	Y☐	N☐	Malaise (Fatigue/Tiredness)	Y☐	N☐	Unintended Weight Loss	Y☐	N☐
Insomnia (Unable To Sleep)	Y☐	N☐	Night Sweats	Y☐	N☐	Weakness	Y☐	N☐
Intended Weight Gain	Y☐	N☐	Obesity	Y☐	N☐			
INTEGUMENTARY (SKIN AND/OR BREAST)								
Acne	Y☐	N☐	Hx Ulcer	Y☐	N☐	Rashes	Y☐	N☐
Contact Dermatitis (Rash From Something Touching Your Skin)	Y☐	N☐	Keloids (Scar Overgrowth)	Y☐	N☐	Scars	Y☐	N☐
	Y☐	N☐	Pigment Change	Y☐	N☐			
Dryness	Y☐	N☐	Pruritus (Itching)	Y☐	N☐			
ALLERGIC/IMMUNOLOGIC								
AIDS	Y☐	N☐	Lupus	Y☐	N☐	Rheumatoid Arthritis	Y☐	N☐
Collagen Vascular Disease	Y☐	N☐	Pyoderma Gangrenosum	Y☐	N☐	Scleroderma	Y☐	N☐
HIV	Y☐	N☐						
EYES								
Blindness	Y☐	N☐	Contact Lenses	Y☐	N☐	Optic Neuritis	Y☐	N☐
Blurred Vision	Y☐	N☐	Glasses	Y☐	N☐	Retinal Detachment	Y☐	N☐
Cataract Removal	Y☐	N☐	Glaucoma	Y☐	N☐			
Cataracts	Y☐	N☐	Macular Degeneration	Y☐	N☐			
EARS, NOSE, MOUTH, THROAT								
Chronic Sinusitis (Recurrent Sinusitis)	Y☐	N☐	Eustachian Tube Problems	Y☐	N☐	Mid Ear Implants	Y☐	N☐
Dentures	Y☐	N☐	Hearing Loss	Y☐	N☐	Partial Dentures	Y☐	N☐
Difficulty Swallowing	Y☐	N☐	Herpes Simplex (Cold Sores)	Y☐	N☐	Sinus Surgery	Y☐	N☐
Ear Surgery	Y☐	N☐	Meniere's Disease	Y☐	N☐	Upper Respiratory Infection (Recent)	Y☐	N☐
RESPIRATORY								
Apnea	Y☐	N☐	COPD (Emphysema)	Y☐	N☐	SHORTNESS OF BREATH	Y☐	N☐
Asthma	Y☐	N☐	Oxygen Dependence	Y☐	N☐	Spontaneous Pneumothorax (Lung Collapse)	Y☐	N☐
Blood Tinged Sputum	Y☐	N☐	Pulmonary Fibrosis	Y☐	N☐			
Bronchitis	Y☐	N☐	Respiratory Infection	Y☐	N☐	Tuberculosis	Y☐	N☐
Chronic Cough	Y☐	N☐	Seasonal Allergies	Y☐	N☐	Wear Supplemental Oxygen	Y☐	N☐
Cold Symptoms	Y☐	N☐	Snoring	Y☐	N☐	Wheezing	Y☐	N☐
CARDIOVASCULAR (HEART)								
Angina (Chest Pain)	Y☐	N☐	Hypotension (Low Blood Pressure)	Y☐	N☐	Palpitations	Y☐	N☐
Arrhythmia (Abnormal Heartbeat)	Y☐	N☐	MI (Heart Attack)	Y☐	N☐	PND (Have To Sit Up To Catch Your Breath When Sleeping)	Y☐	N☐
Chest Pain	Y☐	N☐	Murmur	Y☐	N☐			
CHF (Heart Failure)	Y☐	N☐	Orthopnea (Difficulty Breathing When Lying Flat On Your Back)	Y☐	N☐	Shortness of Breath with Exertion	Y☐	N☐
Defibrillator	Y☐	N☐						
Hypertension (Elevated Blood Pressure)	Y☐	N☐	Pacemaker	Y☐	N☐			
CARDIOVASCULAR (Peripheral)								
Arterial Surgery	Y☐	N☐	Leg Swelling	Y☐	N☐	Varicose Veins	Y☐	N☐
Claudication (Pain with Exercise/Walking)	Y☐	N☐	Necrosis/Gangrene	Y☐	N☐	Vein Surgery	Y☐	N☐
DVT (Blood Clot in Leg)	Y☐	N☐	Rest Pain	Y☐	N☐			

Patient Name: _____ DOB _____

GASTROINTESTINAL								
Acid Reflux	Y☐	N☐	Cirrhosis of Liver	Y☐	N☐	Liver Disease	Y☐	N☐
Anorexia	Y☐	N☐	Constipation	Y☐	N☐	Malnutrition	Y☐	N☐
Ascites	Y☐	N☐	Diarrhea	Y☐	N☐	Vomiting	Y☐	N☐
Blood In Stools	Y☐	N☐	Dysphagia (Difficulty Swallowing)	Y☐	N☐	Nausea	Y☐	N☐
Bowel Incontinence	Y☐	N☐	Hepatitis	Y☐	N☐	Obesity	Y☐	N☐
Bulimia	Y☐	N☐	Hiatal Hernia	Y☐	N☐	Stomach Ulcers	Y☐	N☐
Change In Appetite	Y☐	N☐	Jaundice	Y☐	N☐	Colostomy (Colon Pouch)	☐	☐
GENITOURINARY								
Chronic Renal Insufficiency	Y☐	N☐	Foley Catheter	Y☐	N☐	Nocturia (Waking up to Urinate)	Y☐	N☐
Cystostomy	Y☐	N☐	Hemodialysis	Y☐	N☐	Peritoneal Dialysis	Y☐	N☐
Dysuria (Pain with Urination)	Y☐	N☐	Intermittent Catheter	Y☐	N☐	Suprapubic Catheter	Y☐	N☐
ESRD (Renal Failure)	Y☐	N☐	Kidney Transplant	Y☐	N☐	Urinary Frequency	Y☐	N☐
MUSCULOSKELETAL								
Alteration of Gait	Y☐	N☐	Joint Stiffness	Y☐	N☐	Painful Nails	Y☐	N☐
Arthritis	Y☐	N☐	Joint Swelling	Y☐	N☐	Previous Fracture	Y☐	N☐
Changes in Feet	Y☐	N☐	Muscle Wasting	Y☐	N☐	Previous Amputation	Y☐	N☐
Charcot	Y☐	N☐	Myalgias (Muscle Pain)	Y☐	N☐			
NEUROLOGICAL								
Dizziness	Y☐	N☐	Paraplegia	Y☐	N☐	Stroke (CVA)	Y☐	N☐
Focal Headaches	Y☐	N☐	Parkinson's Disease	Y☐	N☐	Syncope (Passing Out)	Y☐	N☐
Migraine	Y☐	N☐	Quadriplegia	Y☐	N☐	TIA (Mini Strokes)	Y☐	N☐
Muscular Dystrophy	Y☐	N☐	Seizures	Y☐	N☐	Weakness	Y☐	N☐
Neuropathy	Y☐	N☐	Spinal Cord Injury	Y☐	N☐			
ENDOCRINE								
Addison's Disease	Y☐	N☐	Hyperglycemia (High Blood Sugar)	Y☐	N☐	Hypothyroidism	Y☐	N☐
Cushing's Disease	Y☐	N☐	Hyperthyroidism	Y☐	N☐	Thyroid Disease	Y☐	N☐
Diabetes	Y☐	N☐	Hypoglycemia (Low Blood Sugar)	Y☐	N☐			
LYMPHATIC/HEMATOLOGIC								
Bleeding Disorder	Y☐	N☐	Hypercoaguable (Clotting Disorder)	Y☐	N☐			
Bruising	Y☐	N☐	Lymphedema	Y☐	N☐			
PSYCHIATRIC								
Anxiety	Y☐	N☐	Depression	Y☐	N☐	Psychosis	Y☐	N☐
Bipolar	Y☐	N☐	Impaired Judgment	Y☐	N☐	PTSD (Post Traumatic Stress Disorder)	Y☐	N☐
Claustrophobia (Fear of Closed Spaces)	Y☐	N☐	Memory Loss	Y☐	N☐			
Dementia/Alzheimer's	Y☐	N☐	Panic Attacks	Y☐	N☐			

Patient Name: _____ DOB _____

HYPERBARIC								
Asthma	Y☐	N☐	Ear Surgery	Y☐	N☐	Recent High Fevers	Y☐	N☐
Cancer History	Y☐	N☐	Optic Neuritis	Y☐	N☐	Seizures	Y☐	N☐
Cataract Removal	Y☐	N☐	Previous Hyperbaric Treatment	Y☐	N☐	Spontaneous Pneumothorax (Lung Collapse)	Y☐	N☐
Cataracts	Y☐	N☐	Recent Administration of:					
Chronic Sinusitis	Y☐	N☐	1. Cisplatinum	Y☐	N☐	Steroid Use	Y☐	N☐
Congenital Spherocytosis	Y☐	N☐	2. Adriamycin	Y☐	N☐	Thoracic Surgery	Y☐	N☐
COPD/Emphysema	Y☐	N☐	3. Bleomycin	Y☐	N☐			

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or authorized representative must attach documentation of such status.)

Date

_____ _____

Printed Name of Authorized Representative

Relationship/Capacity to Patient

_____

Address of Authorized Representative (Street)

_____

Address of Authorized Representative (City, State, Zip)

_____ _____

Cell Phone Number of Authorized Representative

Home Phone Number of Authorized Representative

HMS HYPERBARIC MEDICAL SERVICES Wound Care & Dive Medicine

Your Partners In Healing

HCMG HYPERBARIC CONSULTANTS MEDICAL GROUP

Hyperbaric Medical Services
2107 O'Farrell Street
San Francisco, CA 94115

Phone: (415) 345-1246
Fax: (415) 829-7632

www.HyperbaricMedicalServices.com

Patient Name: _____ DOB _____

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OFFICE USE
Patient Name: _____ MRN: _____

AGREEMENT OF FINANCIAL RESPONSIBILITY

We are pleased to have the opportunity to provide medical services to you. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to before any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- All procedures, visits, dressing changes, diagnostic test, and facility charges will be filed with your insurance company.

YOU WILL RECEIVE (2) BILLS FOR SERVICES RENDERED:

From the Physician: with Hyperbaric Consultants Medical Group.

From the Facility: Hyperbaric Medical Services.

- You will be financially liable for any balances deemed patient responsibility by your insurance company. This includes deductibles, coinsurance, and copays.
- It is your responsibility to know your own insurance coverage, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.
- We will check your eligibility with your insurer. We will obtain authorization for treatment from your insurance company when required. It will be your responsibility to maintain benefits throughout your treatment. Please be advised that even with pre-authorization, payment of benefits by your insurance company is not a guarantee. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Please understand some insurance coverage have Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

I have read the financial policies outlined above, and my signature below serves as an acknowledgment of a clear understating of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Print Patient/Responsible Party Relationship to Patient

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COMMUNICATING WITH YOU

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Patient Name: _____

What pronouns do you prefer that we use when talking about you? (check all that apply)

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs

☐ Other. Please specify: _____

Home Number: _____

☐ Ok to leave message with detailed information
☐ Leave message with call back numbers only

Cell Number: _____

☐ Ok to leave message with detailed information
☐ Leave message with call back numbers only
☐ Leave TEXT message with call back numbers only

Work Telephone: _____

☐ Ok to leave message with detailed information
☐ Leave message with call back numbers only
☐ NEVER CALL AT WORK

Fax Communication: _____

☐ Ok to fax at the number listed above

Email: (PRINT)_____

☐ Ok to email detailed information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patients consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will give us permission to provide information only to those people listed below.

I authorize Hyperbaric Consultants Medical Group and this facility to release my information to the following individual(s):

Name / Phone Number	Relationship	Options (Check all that apply)
		☐ Billing information ☐ Appointment information ☐ Medical/Health information
		☐ Billing information ☐ Appointment information ☐ Medical/Health information

This request surpasses any prior request for communication of information I may have made and will remain in effect until written notification from the patient and/or responsible party.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative *Date*

_____ _____

Name of Patient/Name of Authorized Representative (Print) *Relationship to patient*

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PATIENT INFORMATION SHEET

Please Print

HYPERBARIC CONSULTANTS MEDICAL GROUP

PATIENT

Patient Name: _____ Date of Birth: _____

Age: _____ Social Security#: _____ Race: _____

What is your current gender identity? (Check ALL that apply)

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer

☐ Additional category (please specify): _____ ☐ Decline to answer

What sex were you assigned at birth? (Check one) ☐ Male ☐ Female ☐ Other ☐ Decline to answer

Relationship Status: ☐ Married ☐ Single ☐ Widow ☐ Widower ☐ Separated ☐ Divorced ☐ Significant other

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Cell Phone#: _____

Email: _____

Patient's Employer: _____ Employer Phone#: _____

Emergency Contact: _____

Phone#: _____ Relation: _____

PHYSICIANS

Primary Physician: _____ Phone#: _____

Referring Physician: _____ Phone#: _____

☐ Check if same as above

INSURANCE

Primary Insurance: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Workman's Compensation

Case Manager: _____ Phone#: _____

Name of Responsible Party: _____ Relation: _____

(If Not Patient, Print Name of Guarantor)

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans, to this office. This assignment will remain in effect until revoked by me in writing. I understand I am responsible for all charges not paid by my insurance. I authorize this office to secure payment.

I authorize consultative services and related treatment by HYPERBARIC CONSULTANTS MEDICAL GROUP, this FACILITY, and its agents along with the release of any necessary medical information needed in my care, or in the processing of medical claims to HYPERBARIC CONSULTANTS MEDICAL GROUP, this FACILITY, and its agents. I also assign the payment of medical benefits for the care and services provided to HYPERBARIC CONSULTANTS MEDICAL GROUP, this FACILITY, and its agents.

I certify that the information provided is true and correct to the best of my knowledge. I will notify HYPERBARIC CONSULTANTS MEDICAL GROUP and this FACILITY of any changes in the above information immediately.

_____

Signature of Patient/Parent/Guardian or Authorized Representative *Date*

(Guardian or authorized representative must attach documentation of such status.)

_____

Printed Name of Authorized Representative *Relationship/Capacity to Patient*

_____

Address and Telephone Number of Authorized Representative

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Please Print

Patient Name: _____ Date of Birth: _____

Phone # (H) _____ Phone # (W) _____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE NOTE: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone #:** _____

Facility Address: _____ **Facility Fax #:** _____

City: _____ **State:** _____ **Zip:** _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other: _____
- ☐ Specific Information Requested: _____

_____

Dates and Type of information to disclose:

- ☐ Change of Insurance or Physician
- ☐ Continuation of care
- ☐ Referral
- ☐ Other _____

Release To: Hyperbaric Medical Services **Fax #:** (415) 829-7632

Address: 2107 O'Farrell Street **Phone #:** (415) 345-1246

City: San Francisco **State:** CA **Zip:** 94115

☐ **Please mail records.** ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy**. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/ Parent/ Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

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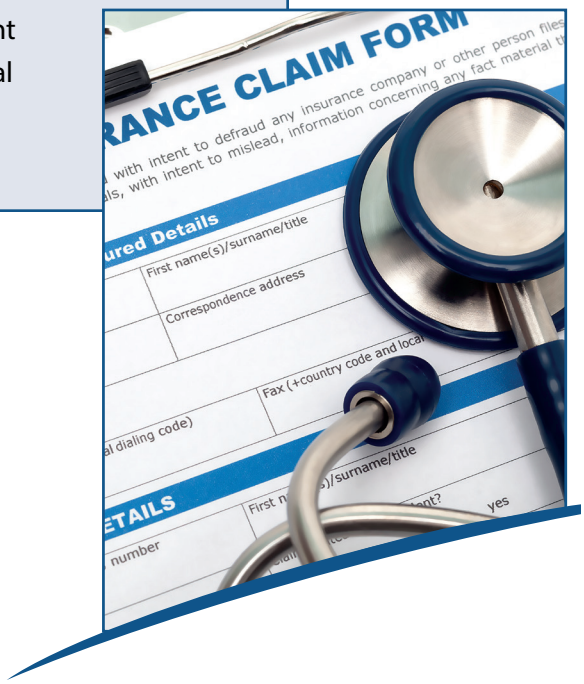
PATIENT GUIDE TO INSURANCE COVERAGE

IMPORTANT FINANCIAL INFORMATION

We realize the wound care and/or hyperbaric oxygen therapy you will be receiving may be a new experience for you and your family. These specialized treatments often require significant financial resources which can vary among different insurance company plans. This brochure is intended to explain the financial resources you have available so you can better understand and plan your financial responsibility.



Insurance Precertification and Financial Procedures

Once your physician prescribes wound care and/or hyperbaric oxygen therapy, your insurance company requires us to contact them to determine if your treatment is covered with your diagnosis as well as verify your personal financial responsibility for the treatment.

Generally, it takes at least 3 business days, and sometimes as long as 7 business days, to complete the insurance verification process. There are different types of personal financial responsibility that you may have based on your individual insurance plan. The most common types are outlined below:

- **Deductible** - this is the amount you must pay before your insurance company will start paying for any services. This is usually a fixed dollar amount.
- **Co-Payment** - this is a specific amount ($5 - $100) that you pay for specific services, such as doctor's office or emergency room visits. Co-payments are due at the time of service.
- **Coinsurance** - this is the percentage of the medical cost you are responsible to pay. This percentage may apply to all or specific services until you reach a certain out-of-pocket amount. (10% - 60% owed by the patient.) This coinsurance amount may be collected per treatment based on an estimate of your services.
- **Out-of-Pocket** - this is the flat dollar amount you are required to pay before your insurance pays 100% of the cost of your care. This amount is not reimbursed by your insurance company. This amount will accrue based on the coinsurance % of your plan. Example: If a patient's out-of-pocket maximum is $4,000 and the patient has paid $4,000 out of their pocket, the patient no longer pays a coinsurance amount.

Your personal financial responsibility for treatment, such as a deductible, coinsurance, out-of-pocket and/or co-payments, has been provided to us by your insurance company as part of the coverage verification process.

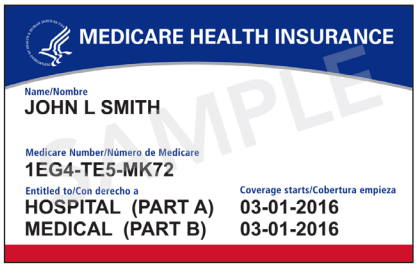
You will receive 2 bills for services rendered:

1) From the physician, Hyperbaric Consultants Medical Group.
2) From Hyperbaric Medical Services.

NEED HELP?

Your insurance/billing questions and concerns can be discussed with a Billing Specialist assigned to the center where you received treatment. Contact your Billing Specialist, indicated below, for assistance during our normal business hours, Monday through Friday, 8:00 am - 4:00 pm.

ATTENTION MEDICARE PATIENTS



TRADITIONAL MEDICARE

Traditional Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). Our services fall under Medicare Part B. Many patients that have traditional Medicare also carry secondary supplemental insurance, such as AARP or United American.

- ☑ **Deductible:** At the beginning of each year, Medicare will assess a deductible that must be met before they will pay on any claims. Some secondary supplemental policies will cover this deductible amount. If not, it will fall to the patient for payment.
- ☑ **Coinsurance:** Traditional Medicare covers 80% of allowed charges, leaving 20% coinsurance. Again, some secondary supplemental policies will cover this coinsurance amount.

Some supplemental secondary policies have their own deductibles or copays that they will assess to claims.

If the patient does not have a secondary supplemental policy, they will be financially responsible for any charges assessed to deductible or coinsurance.

MEDICARE ADVANTAGE/REPLACEMENT PLAN

These are commercial insurance plans that take the place of Traditional Medicare. They are all inclusive, with no secondary supplemental policy.

- ☑ **Copay:** Patient's on Medicare Advantage plans typically have a copay requirement for all primary care and specialist's office visits.
- ☑ **Deductible:** Some Medicare Advantage plans have a deductible amount they assess to claims. This amount must be met prior to the insurance making payment on any charges. This amount is payable by the patient.
- ☑ **Out of Pocket Maximum:** Medicare Advantage plans have a maximum amount they will assess as patient's responsibility. Once this maximum has been met, they will cover all charges at 100%.

For more information on medicare go to: www.medicare.gov.

BILLING SPECIALIST

HYPERBARIC ADMINISTRATIVE SERVICES, LLC

Phone: 770-422-0517

Fax: 678-638-7015

INSURANCE DISCLAIMER

"A quote of benefits and/or authorization does not guarantee a payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service"

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PATIENT BILL OF RIGHTS

As a patient, you have these rights:

1. Actively participate as a member of your wound care and/or hyperbaric medicine team if you are able and willing.
2. Have your medical problem assessed and monitored by trained healthcare personnel.
3. Have your questions about wound care and/or hyperbaric medicine answered openly and completely.
4. Know what other treatment options are available to you.
5. Know the benefits, risks, and side effects of your wound care and/or hyperbaric treatments.
6. Receive timely and cost effective wound care and/or hyperbaric care.
7. Seek other opinions about your wound care and/or hyperbaric related problem if you so desire and consult a specialist as necessary.
8. Have your pain adequately controlled, under supervision of your primary physician.

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San Francisco, CA 94115

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Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

continued on next page

Your Rights *continued*

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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www.HyperbaricMedicalServices.com

Effective Date: October 2020

SF10882_210505 HIPPA Booklet Full Sheet.indd

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PATIENT ACKNOWLEDGMENT FORM

Printed Name

Date of Birth

I understand that the patient's health information is private and confidential. I understand that Hyperbaric Consultants Medical Group and this Facility work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Hyperbaric Consultants Medical Group and this Facility 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.)

Hyperbaric Consultants Medical Group and this Facility 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 available to all patients. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgment.

Hyperbaric Consultants Medical Group and this Facility may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Hyperbaric Consultants Medical Group or this Facility will provide me with the most current "Notice of Privacy Practices".

Within the "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 by specified methods of communications or alternative location.

Hyperbaric Consultants Medical Group and this Facility 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 Hyperbaric Consultants Medical Group and this Facility 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 Hyperbaric Consultants Medical Group and this Facility's "Notice of Privacy Practices".

☐ AM
☐ PM

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or authorized representative must attach documentation of such status.)

Date and Time

Printed Name of Authorized Representative

Relationship/Capacity to Patient

Address and Telephone Number of Authorized Representative

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PHARMACY INFORMATION

Patient Name _____ Date of Birth _____

Primary Pharmacy _____

Address _____

_____

Phone _____ Fax _____

Secondary Pharmacy _____

Address _____

_____

Phone _____ Fax _____

RESET FORM