Hyperbaric Oxygen Therapy Intake Form

Appointment Time: ____________ Adjustment Before: _____ After: _____ or No: _______ Room: ____1 (or) ____ 2

Date: _________ /_________ /____________

Name: __________________________________ DOB: _________ /_________ /____________

Phone: _________-________-_________ Email: _______________________________________

Address: ____

City: _____________________________ State: ______________ Zip: _______________

Have you ever had Collapsed Lung? ☐ **Yes** ☐ **No**

<u>What medical issues are you hoping to improve with HBOT?</u>

- ☐ Autoimmune Disorders
- ☐ Neurological Conditions
- ☐ Stress Relief
- ☐ Diabetes II
- ☐ Improve Athletic Performance
- ☐ Arthritis
- ☐ Physical Healing and Recovery
- ☐ Weight Management
- ☐ Cancer
- ☐ Other:____

Are you pregnant or think you might be pregnant? ☐ **Yes** ☐ **No** If yes, How many months ___________

Do you have a pacemaker? ☐ **Yes** ☐ **No**

Have you had any surgical procedures? ☐ **Yes** ☐ **No**

If so, please describe: ____

Do you have emphysema/COPD/Chronic Bronchitis? ☐ **Yes** ☐ **No**

If so, please describe: ____

Do you have congenital spherocytosis? ☐ **Yes** ☐ **No**

If so, please describe: ____

<u>Office Use only</u>

Arrival time: ____:_____ Frequency: _______ CA: ________ Time In: ____:_____ / Time Out: ____:_____ Package Visit: _____

Do you or have you in the past experienced head trauma? ☐ **Yes** ☐ **No**

If so, please describe: ____

____

Do you have uncontrolled high blood pressure or cardiovascular disease? ☐ **Yes** ☐ **No**

If so, please describe: ____

____

Please mark any the following medications you may be taking:

☐ Bleomycin / Blenoxane *(Cancer Medication)*

☐ Cisplatin / Platinol *(Chemo Medication)*

☐ Sulfamylon / Mafenide *(Antibiotic Medication)*

☐ Disulfiram /Antabuse *(Alcoholism Medication)*

☐ Doxorubicin / Adriamycin / Rubex *(Chemo Medication)*

Do you have diabetes? ☐ **Yes** ☐ **No**

(If you have diabetes, it is important that you check your blood glucose levels before and after each HBOT dive and let the Doctor or CA know if you do not feel well.)

Please mark any conditions which apply to you currently:

☐ Past/Recurrent Ear Trauma

☐ Otic Barotraumas

☐ Cold/Flu-Like Symptoms

☐ Sinusitis/Sinus Infections

☐ Ear Infection

☐ Excessive CO_2 Exposure

☐ Recent Alcohol Consumption

☐ Asthma *(not controlled with medication)*

☐ Upper Respiratory Infection

☐ Eustachian Tube Dysfunction

☐ High Fever (>100.4)

☐ Seizures *(not controlled with medication)*

If you marked any of the above, is it recommended that you WAIT to use the Hyperbaric chamber.

Important things to know regarding HBOT:

- Be sure to swallow often during the pressurization process to clear your ears. If you cannot clear your ears, notify the CA/Doctor.
- Feel free to take a book, electronic tablet, cell phone in the chamber with you.
- Refrain from bringing any sharp objects in the chamber.
- Any type of clothing is acceptable for the chamber; however, comfortable clothing is typically used.
- Do not wear shoes inside the chamber.

Patient Name (Printed): X____

Patient Name or Guardian (Signature): X______________________________ Date: ______ / _______ /_________

HEALTHY LIFE CHIROPRACTIC STATEMENT OF PATIENT OFFICE POLICIES

Welcome to Healthy Life Chiropractic. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have. Our focus is for you, our patient and your family to have an extraordinarily positive experience. We believe that a clear definition of your prescription of care to regaining your health, setting measurable goals (Activities of Daily Living) and maintaining your health is critical. Following your prescription of care is vital to your success. We also believe that clear definition of office policies will allow you, the patient; and Healthy Life Chiropractic to concentrate on the big issue—**REGAINING AND MAINTAINING YOUR HEALTH**.

Your prescription of care is based on medical necessity as deemed appropriate by the Doctor of Chiropractic. As such, Re-evaluations are completed in this office to measure progress of care and medical necessity, regardless of insurance coverage, insurance carrier or no insurance coverage. If you are out of care for three (3) or greater months, a re-evaluation will be required to correctly assess a possible change in adjusting technique and/or an underlying health issue that would change your prescription of care. It is the policy of this office to re-evaluate through x-ray every two (2) years, to correctly assess a possible change in adjusting technique and/or an underlying health issue that would change your prescription of care. Any outside products are NOT allowed to be brought into the office for use during any service. This is due to other patients and/or employees having allergies and sensitivities. Only in-house products may be added to the service. Please notify a staff member in the event you have a sensitivity or allergy. **Patient/Legal Guardian Initials: _____________**

CHIROPRACTIC, NEW PATIENT, RE-EVALUATION, RE-ESTABLISH EVALUATION, ROF, COLD LASER, HEALTH RESPONSE TESTING (HRT), HBOT, DECOMPRESSION, EAR CONING & IONIC FOOTBATH APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:

Appointments have been scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the *frequency* of visits that counts, and not the days. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the front desk assistant. We require 24-hour notice for any cancelled or rescheduled appointments. **Failure to show for any scheduled appointment without a 24-hour notification will result in a $50.00 charge payable by YOU, not your insurance company**. You are expected to re-schedule missed appointments in order to comply with your prescribed treatment plan. Please keep in mind that re-scheduling an appointment is always subject to availability. **Our office utilizes email and/or text messaging to remind you of upcoming appointments. Not confirming your appointment via call, text, or email, does not constitute a canceled appointment. Please refrain from using a cell phone in all areas of the office. If necessary to take a call, please step outside after informing the front desk. Patient/Legal Guardian Initials: _____________**

NEUROMUSCULAR RE-EDUCATION (MASSAGE) APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:

Appointments have been scheduled for your convenience. Children are not allowed to be in the room during your appointment. **We require a 24-hour notice for any canceled or re-scheduled appointments. Failure to show for an appointment without notification will result in a $75.00 (1 hour) $112.50 (1.5 hour) or $150.00 (2 hour) charge payable by YOU, *not your insurance company*. Not confirming your appointment via call, text, or email, does not constitute a canceled appointment.** If you are more than 20 minutes late for your neuromuscular re-education (massage) appointment you will be subject to continuing with the service based on appointment book availability, possibly rescheduling, or charged the **above** cancelation fee schedule. Should you have a scheduled massage appointment and are unable to complete “your entire scheduled time” you are still financially responsible for the total scheduled time allocated for you during your scheduled appointment. Should you be billing insurance for this visit, your insurance company is not responsible for cancelation fees or time not utilized by the patient, so therefore, the lost scheduled time is payable by you. If at any time during the session the therapist is uncomfortable with your behavior the therapist reserves the right to end the session and the full time allotted will be billed to you. **It is unethical and illegal for this office to bill your insurance company for services not rendered on the date in question. Our office utilizes email and/or text messaging to remind you of upcoming appointments for Neuromuscular Re-Education (Massage). Not confirming your appointment via call, text, or email, does not constitute a canceled appointment. Please refrain from using a cell phone in all areas of the office. If necessary to take a call, please step outside after informing the front desk. Patient/Legal Guardian Initials: _____________**

PRODUCTS, SERVICES AND PACKAGES SOLD IN THE OFFICE:

All products that are sold in the office have a **NO RETURN/NON-REFUNDABLE POLICY**. (Supplements, Pillows, Oils, CBD, Neck Collars, Foam Rollers, ETC.) Orthotics can be returned to the company under Foot Levelers guidelines. Once a particular service package is purchased, they are **NON-REFUNDABLE AND NON-TRANSFERABLE** and may not be applied to any other purchases and/or services within the office. This applies to all services and packages. Packages cannot be split between patients, there is a **ONE year expiration** on package cards and gift certificates. Should you terminate your care and/or move from the region with package visits or services untendered, please request a refund and allow thirty (30) from date of request for refund to be processed. **ALL SALES ARE FINAL. Patient/Legal Guardian Initials: _____________**

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APPOINTMENT REMINDERS:

Healthy Life Chiropractic uses a appointment reminder (text and email) program for our patient reminders, sales, promotions and important notifications. You will receive a welcome letter via text message and/or e-mail for you to opt-in or opt-out. If you choose to opt-out, you will not be able to receive appointment reminders. **Please remember this can result in a NO SHOW FEE if you opt-out and do not show up for your appointmen**ts. **Patient/Legal Guardian Initials: _____________**

FINANCIAL RESPONSIBILITY WITH AND WITHOUT INSURANCE:

Charges for treatment are due at the time the service is provided or a product is ordered. Please be aware that some services in this office are not covered by ANY insurance carrier and are excluded from some insurance carriers. This office, to the best of our knowledge, informs our patients of their insurance coverage. However, financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medical insurance is a contract between ***you*** and ***your*** insurance carrier. The benefits quoted by your insurance carrier are not a guarantee of payment and are subject to review based on the terms of your individual contract. All insurance coverage quotes are merely estimates based on the information quoted by your insurance carrier. All services rendered are ultimately your (the patient's or patient's legal guardian's) financial responsibility and are payable in full. Services quoted and received by you may be quoted as covered but are denied (non-covered) by your insurance carrier will be assigned to you. ***Any balance is due within 30 days of notice***. ***Please note that you are responsible for knowing the limitations of your coverage.*** It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill. Most insurance companies process claims within 30 days of receipt. Should your insurance company send you a check for services rendered that should have been paid to Healthy Life Chiropractic you will have 10 days to pay Healthy Life Chiropractic for those services. If you have an HRA (Health Reimbursement Account) account, it is your responsibility to keep up with your available HRA funds. If you have an HSA (Health Savings Account) you are responsible for your balance at the time of services rendered in the office. **Patient/Legal Guardian Initials: _____________**

STATEMENTS:

In an effort to reduce healthcare costs, it is the policy of HLC to mail as few statements as possible. HLC will email statements to the email address on file. Should an email not be provided, and a paper statement has to be sent by postal mail, *each mailed invoice will be assessed with a $2.00 paper statement fee*. If a patient balance is incurred, responsible parties are encouraged to mail the payment directly to HLC upon receiving the EOB (explanation of benefits) from their insurance company. If 30 days have passed after the first generated statement and it is necessary for HLC to mail a second statement (because no payment has been received) a flat interest charge of 12% of the balance, but not less than $5.00 will be added to the account. **If no payment is received within 10 business days after the mail date of the second statement, the account will be reviewed with a 10-day demand letter certified mail to the address on file. If payment is not received following the 10-day period, the account will be turned over to the collection agency or filed with the county court system in the county you reside in. All collection fees and court fees are paid by the patient. ALL ACCOUNTS TURNED OVER TO THE COLLECTION AGENCY WILL ALSO BE RESPONSIBLE FOR THE COLLECTIONS AGENCY FEE OF 40% OF THE BALANCE OWED. Patient/Legal Guardian Initials: _____________**

RETURNED CHECKS:

There will be a **$50.00 fee** imposed for all checks returned to this office. All returned checks must be taken care of within 10 days of receipt. Any unpaid amounts after 10 days will be referred to our collection agency or filed with the county court system in the county you reside in. **Patient/Legal Guardian Initials: _____________**

VOLUNTARY TERMINATION OF CARE:

It is the policy of this office that should you choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be **immediately due and payable**; regardless of your balance is from Self-Pay visits, Insurance visits and/or the UCCAFF agreement. Should you be in a UCCAFF agreement, your charges will be reversed to regular cost and the balance will be due in full. **Patient/Legal Guardian Initials: _____________**

PATIENT RECORDS REQUEST:

Any records/documents requested from the office requires ten (10) business days for completion. We do not send any records/documents electronically. Fees may apply. Should you need FMLA, and/or Work-Related forms filled out, fees will apply for these forms and are payable by the patient at the time the form is requested to be filled out by the Doctor. Please allow ten (10) business days for this form to be completed. This office does not file disability ratings. This requires a specific certification that HLC does not have. **Patient/Legal Guardian Initials: _________**

I, the Patient (or) Parent/Legal Guardian undersigned below, have read "Statement of Patient Office Policies" (above) and I agree to abide by these policies.

Patient Name (Printed): X____ **Date:** ________ / _________ /__________

Patient (or) Parent/Legal Guardian Signature: X____

PT#: __________