**North Shore Health and Hyperbarics**
**290 Community Drive, Great Neck, NY 11021**
**Phone: 516-487-1902 Fax: 516-487-4156**

# Patient Registration

Date: ____/____/ _____

Last Name: _____ First Name: _____ Gender: □ M □ F

Date of Birth: _____ SSN: _____-_____-_____ Marital Status: _____

Address: _____

City, State, Zip: _____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Work: (____)_____-_____

How did you hear about us? _____ Email:_____

**Please provide: Insurance Card(s) and Photo ID**

Primary Care Doctor: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

**Emergency Contact**

Name of local friend of relative: _____ Relationship: _____

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

**Employment Information**

Employer Name: _____Occupation: _____

Address: _____ Phone #: _____

**Chief Complaint / Reason for Visit:**

_____

_____

_____

Height: _____ Weight: _____

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# Cancellation, Lateness, and Fee Agreement

**Cancellation and No Show**
We request at least 24 hours notice if you are unable to make appointment. Please leave a message if you call after hours. There is a $50 cancellation for failure to cancel the appointment without 24 hours notice. If there is a valid reason for no cancellation, we will waive the fee. We reserve the right to revoke this policy if we suspect that it is being abused.

**Lateness**
We request that you show up **15 minutes before your appointment** so that we can best serve you and other patients. Lateness puts a strain on our staff. In the event that you are more than 15 minutes late for an appointment, we reserve the right to charge a late fee of $50.00. If you are 30 minutes late, we reserve the right to charge a late fee of $100.00. In addition, your treatment may be canceled.

**Fee Agreement**
Payment for services rendered is expected in full prior to start of treatment. The usual and customary fee for treatment is $3,000.00. **If you are covered by insurance** - we will bill your insurance company accordingly. You will be responsible for all deductibles and copays at the time of service or upon receipt of invoice. Payment for services rendered is expected in full prior to start of treatment. If insurance does reimburse for treatments, we will reimburse patients within 90 days. These payments are not guaranteed and may be recalled by insurance without notice.

If your insurance carrier will not cover your treatment, you will be billed $350.00 per treatment. Payment for services rendered is expected in full prior to the start of your treatment.

## Acknowledgement

I, _____, am being treated at North Shore Health and Hyperbarics, or am the responsible party for payment (including all patient balance responsibility in compliance with my insurance policy). I understand that I am responsible for all insurance deductibles, co-insurance and co-payments and am responsible for all amounts not covered by insurance. I understand that failure to comply with the above-mentioned policies may result in additional fees. Accepted methods of payment are cash or check.

**Patient or Responsible Party**

Signature: _____ Date: _____

Print Name: _____

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# Rules and Regulations

1. All patients and family members who will be going into the chamber are required to have a recent chest x-ray, unless otherwise stated by their physician. If a chest x-ray is required, the report must be received and cleared by our physician on staff prior to your first treatment.

2. 100% cotton clothing must be worn by those going into the chamber.
Clothing **may not** have:
Buttons, iron-on decals, snaps, bra with an under wire or velcro

100% cotton scrubs are available to you at our facility. If you choose to bring your own 100% cotton clothing, it **must be approved** by the technician before entering the chamber each time.

3. You **may not** have on:

| | | | |
|---|---|---|---|
| deodorant | hair accessories | hearing aids | perfume |
| Watches | mousse, gel, or hairspray | makeup | contact lenses |
| Jewelry | dentures | other prostheses | any metal objects |
| Thermacare: heat wraps, hand or pocket hand warmers | | lotion (any petroleum containing hair or body products) | |

4. Nail polish and/or hair dye must have been applied at least 48 hours prior to your treatment.

5. If you are doing IV therapy, you cannot bring IV medication into the chamber. All other medication routines may continue during your treatment.

6. Eat a balanced meal before going into the chamber. Hyperbaric treatments increase your metabolism and may make you feel hungry. Do not drink any soda or carbonated beverages before your treatment it may upset your stomach.

7. You **may not** bring in any of the following items:
-toys, candy, gum, or sucking candy, blankets, books, newspapers, or magazines
-any electronic devices including cell phones, audio players, video players, Ipods, game boys, etc.

8. You **may bring** in any of the following items:
-diapers – as long as they are covered with 100% cotton pants
-undergarments that are 100% cotton
-eye glasses

9. Do not smoke cigarettes, pipes, cigars, etc during the period that you are coming in for therapy to achieve optimal benefits. Smoking causes vasoconstriction, accumulation of carbon monoxide and wastes, and causes oxygen consumption which is counterproductive to this therapy. If you are going to smoke, **do not do so** at least four hours before your treatment and four hours after your treatment.

10. Do not drink alcohol at least 8 hours prior to your treatment.

11. Things you should let your technician know prior to your treatment:

| | |
|---|---|
| if you are diabetic and have not taken your insulin | if you will be flying |
| if there is a possibility that you are pregnant | if you have been recently hospitalized |
| if there has been a change in your medication | if you did not eat before coming in for your treatment |
| if you have any cold or flu symptoms, fever, sinus or chest congestion | |

I have read the above and my signature attests that I understand and will comply with the above rules and regulations.

Signature: _____ Date: _____

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# Informed Consent for Hyperbaric Oxygenation

**Name: _____ Date of Birth: _____ Date_____**

1. I hereby authorize North Shore Health and Hyperbarics such assistants as he or she may designate to treat me with hyperbaric oxygenation therapy. The procedure including risks, benefits, and alternative therapies have been explained to my satisfaction. **Risks Include:**

   A. **Barotrauma or pain in the ears or sinuses**. I may experience pain in the ears or sinuses. Techniques to prevent pain will be explained by staff. Fluid in the ears Serous Otitis may occur but usually disappear after completion of treatment.

   B. **Cerebral Air Embolism and Pneumothorax.** Whenever there is a rapid change in the ambient pressure there is a possibility of rupture of the lungs with escape of air into the arteries or into the chest cavities outside the lungs. Only slow decompressions are used in hyperbaric oxygen treatment to obviate this possibility.

   C. **Oxygen toxicity.** The risk of oxygen toxicity has been explained to me and will be minimized by never exposing me to greater pressure or longer times than are know to be safe for the body and its organs.

   D. **Risk of fire.** With the use of oxygen in any form there is always a risk of fire, but strict precautions have been taken to prevent this and all applicable codes have been complied with.

   E. **Risk of worsening of near-sightedness.** (Myopia) After twenty or more treatments, especially if I am over forty, it is possible I may experience diminution in my ability to see things far away. I understand that this is usually temporary and that in the majority of patients, vision returns to its pre-treatment level six weeks after the cessation of therapy.

   F. **Maturing or Ripening Cataracts.** In individuals with cataracts it has occasionally been demonstrated that there may be a worsening of the cataracts. I am aware that the practice of medicine and surgery is not an exact science and I have been made no promises or guarantees as to the results of hyperbaric oxygen therapy.

2. I have been informed by the staff of North Shore Health and Hyperbarics that smoking cigarettes, pipes, cigars, or any other form of tobacco and the chewing of tobacco products will result in the ingestion of chemicals into the body which may affect the efficacy and success of hyperbaric treatment. I have been specifically told not to smoke during the entire duration of treatment. I hereby agree to be tested either urine or blood for the presence of nicotine or carbon monoxide in my system.

3. I hereby authorize North Shore Health and Hyperbarics or their employees to take medical photographs for the purposes of teaching or publication. I also understand that I will not be identified by name and that my anonymity will be preserved in any presentation or publication.

4. Females: I am not pregnant and agree to use birth control during the therapy.

I have read and agree to the information above. Hyperbaric oxygen therapy has been satisfactorily explained to me. I hereby understand that I am entering into hyperbaric treatment at my own risk. I hereby give my authorization and consent to the performance of hyperbaric oxygen therapy by North Shore Health and Hyperbarics.

**Patient or Responsible Party**

Signature: _____ Date: _____

Physician's Signature: _____ Print:_____