SOUTHERN OREGON HBOT
1663 WILLIAMS HIGHWAY
GRANTS PASS, OREGON 97527
P - 541.479.1289   F - 888.640.1719

Consent for Hyperbaric Oxygen Therapy

Patient Name: _______________________________________ DOB: ________________________

I, _______________________________ request that Dr. __________________________ and his/her trained assistants perform the following procedure: **HYPERBARIC OXYGEN THERAPY**. I also agree to accept such other supportive and or additional care that his/her professional judgement may dictate during the above procedure.

1. **DIAGNOSIS:**____
2. **REASON FOR PROCEDURE:** To increase the amount of oxygen available to the tissues to enhance wound healing, reduce edema, and to improve the milieu for reducing bacteria in the wound. It is also indicated for treatment of CO poisoning.
3. **ALTERNATIVES:** Standard wound debridement, dressing changes, irrigation of the wound and addition of antibiotics or chemicals that reduce bacteria in the wound. These are the things done now. The use of Hyperbaric Oxygen Therapy is an additional therapy for treating wounds that augments the other methods of management.
4. **RISKS**: I have been made aware that possible risks or side effects of hyperbaric oxygenation include, but are not limited to:

A. BAROTRAUMA or pain in the ears or sinuses - I may experience pain in my ears or sinuses. I also understand that if I am not able to equalize my ears or sinuses that presurization will be slowed or halted and suitable remedies will be applied. I may require placement of tubes in my ears. There is a small risk of rupture of the eardrum or in worse cases a rupture of the oval window causing hearing loss or dizziness. Medications may be given to help with equalization of the pressures.

B. CEREBRAL AIR EMBOLISM and PNEUMOTHORAX - Whenever there is a rapid change in ambient pressure, there is the possibility of rupture of the lungs with escape of air into the chest during decompression. Slow decompressions are used in hyperbaric oxygen treatment to minimize this possibility. This may require a chest tube to treat.

C. OXYGEN TOXICITY - There is a small risk of lung toxicity caused by the high oxygen pressure. There is a small risk of a of a seizure while breathing pure oxygen under pressure.

D. RISK OF FIRE - With the use of oxygen in any form, there is an increased risk of fire, but precautions have been taken to prevent this and applicable codes have been complied with.

E. RISK OF WORSENING NEAR - SIGHTEDNESS (Myopia) - After twenty or more treatments, especially if I am over forty, it is possible that I may experience diminution in my ability to see things far away. I understand that this is believed to be temporary and that vision usually returns to its pretreatment level about six weeks after the cessation of therapy. I understand that it is not advisable to get a new prescription for my glasses until at least eight weeks have passed after hyperbaric therapy.

F. TOOTH SQUEEZE - Sometimes pressurized air or oxygen can get into an area of cavity, broken filling, cap, and/or site of old root canal and cause pressure after ascending and may require dental evaluation or treatment to release the pressure. The could cause discomfort or cost not expected.

5. **PROBABILITY OF SUCCESS**: Hyperbaric Oxygen Therapy has a very high probability of success in those patients who qualify for therapy. As with any mode of treatment, there can be an unexpected failures.

6. **IF THE THERAPY IS NOT DONE**: You may have a higher incidence of failure to heal the wounds risking a long term wound that won't heal or progression of the would that may require amputation. Some wounds will heal after a long time with other therapies.

SOUTHERN OREGON HBOT
1663 WILLIAMS HIGHWAY
GRANTS PASS, OREGON 97527
P - 541.479.1289   F - 888.640.1719

I understand that Hyperbaric Oxygen Therapy consists of being in a chamber at higher than normal atmospheric pressure breathing 100% oxygen. Each treatment will last 1-2 hours with at least 90 minutes of breathing 100% oxygen. The number of treatments vary according to the diagnosis, but a typical therapy will be 20 to 30 treatments. There are circumstances that will alter the number treatments and those circumstances will be explained as needed. The treatments may be terminated at the patient's request at any time.

I have read and understand the prohibited items for Hyperbaric Chamber and I understand that I will be provided specific hyperbaric linen to utilize while in the chamber.

The above information have been explained to me, I have asked questions, and they have been answered to my satisfaction. Furthermore, I understand there may be observers in the treatment room and that pictures may be taken for documentation purposes. _____ (Patient initials)

Print Name of Patient / Patient Representative: ______________________________ DOB: ______

Signature of Patient / Patient Representative: ______________________________ Date: ________

Physician: __________________________ Date: _____________ Time: ____________

Witness: ____________________________ Date: _____________ Time: ____________

SOUTHERN OREGON HBOT
1663 WILLIAMS HIGHWAY
GRANTS PASS, OREGON 97527
P - 541.479.1289 F - 888.640.1719

Notice of Patient Privacy Health Insurance Portability and Accountability Act (HIPAA)

Southern Oregon HBOT is dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others to your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact Southern Oregon HBOT at (541) 479-1289. You may also send a written complaint to the US Department of Health and Human Services.

____

Printed Name

____ ________________

Signature of Patient or Guardian Date

SOUTHERN OREGON HBOT
1663 WILLIAMS HIGHWAY
GRANTS PASS, OREGON 97527
P - 541.479.1289 F - 888.640.1719

Authorization for Release of Information to Family Members

Patient Name____________________________ Date of Birth___________________________

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 patient's consent. If you wish to have your medical or billing information released to family members you must sign this form.

Signing this form will only give information to family members indicated below.

I authorize Southern Oregon HBOT to release my medical and/or billing information to the following individual(s):

1.__________________________________ Relation to Patient:__________________________

2.__________________________________ Relation to Patient:__________________________

3.__________________________________ Relation to Patient:__________________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:____Date:________________________________

SOUTHERN OREGON HBOT
1663 WILLIAMS HIGHWAY
GRANTS PASS, OREGON 97527
P - 541.479.1289 F - 888.640.1719

FINANCIAL ARRANGEMENTS AND CONTACT INFORMATION

We believe that every person has the right to expect the very best professional care we can provide. In turn, we expect cooperation in establishing definite financial arrangements. Accordingly, we have established the following policies.

---

1. The initial Consultation is $160, after the consultation each Hyperbaric dive **requires payment in full at the time of service unless pre-authorized through insurance.**

Fees at time of service prices

(does not include insurance fees)

Soft Chamber - $100.00

Acrylic Chamber - $350.00 per 1 hour session

All subsequent visits are also payment at the time of service.

2. Patients involved in LITIGATION (LAWSUIT) are, just as other patients, responsible for payment at the time of service. Under no circumstances will we “carry” an account until settlement.
3. If you are late for your Hyperbaric Dive, we may need to reschedule your appointment that day and you will be responsible for payment of the missed appointment.
4. If you are late for your Hyperbaric Dive, we may be able to see you that day, however, you **will not** get your full scheduled amount of time, you will get the time remaining of your appointment and the fee remains the same.
5. We reserve the right to bill for missed appointments. This time is set aside for your health care. 24 hour cancellation notice is required, so that time can be used by another patient in our schedule.
6. **PERSONAL CLEANLINESS IS REQUIRED!** Due to the close interpersonal nature of our work and for a comfortable environment for our staff and other patients, please pay close attention to your personal hygiene prior to appointments.
7. SMOKING IS PROHIBITED WITHIN 20 FEET OF OUR BUILDING. You can not smoke prior to your office visit on the day of your appointment. We will disqualify you for your appointment if this request has been broken.
8. I grant this office permission to seek all legal means necessary to collect delinquent monies that I owe. In addition to my outstanding balance, I will reimburse for legal and/or collections fees included in this process.

Patient Name ____________________ Cell Phone ____________________
Street Address ____________________ Home/other Phone ____________________
Mailing Address ____________________ Email ____________________
City/State/Zip ____________________ Drivers License ____________________
Date of Birth ____________________ SSN ____________________
Employer ____________________ Work Phone ____________________
By Whom Were You Referred ____________________ Emergency Contact ____________________
Phone ____________________ Is it ok to leave a detailed messaged when calling: Yes ____ No____
Phone preferred ____________________
My signature is an acknowledgement that I have read the policies above and agree to abide by the same.

____________________ ____________________ ____________

Signature of Patient or Guardian Printed Patient Name Date