145 Vista Avenue Suite #103
Pasadena, CA 91107
(626) 365-1380
healthfitinc.com

New Patient Information Forms (HBOT)

Full Legal Name

Date of Birth

Street Address: Apt./Unit #: City: State: Zip Code:

Email Address Phone #

Emergency Contact Name Emergency Contact Phone # Relationship

Primary Care Physician Specialty

Other Doctors You see Specialty

How did you learn about our practice or whom may we thank for referring you?

MEDICAL HISTORY

Please list any conditions that you have or have had. (i.e. Previous Injuries, Cancer, Diabetes, Stroke, Heart Attack, etc.) Please include date of diagnosis.

	Condition	Date Diagnosed	Date Subsided
1			
2			
3			

Medical Conditions Contradictory to Hyperbaric Oxygen Therapy (please select all that apply)

- ☐ Otic Barotrauma (Ear Drum Injury)
- ☐ Pneumothorax or Punctured Lung
- ☐ Pregnancy
- ☐ Significant Asthma
- ☐ Severe Claustrophobia
- ☐ Eustachian Tube Dysfunction
- ☐ Chronic Obstructive Pulmonary Dysfunction (COPD)
- ☐ Seizures
- ☐ Respiratory Infections

☐ Sinus Damage ☐ Ear Infection ☐ N/A

MEDICATIONS AND SUPPLEMENTS

Please list all the prescription medications and supplements that you are currently taking, as well as the duration and dosage.

	Name	Purpose	Duration & Dosage
1			
2			
3			
4			
5			

Are you experiencing any ear or sinus congestion?

○ Yes ○ No

Please specify:

_____

Have you had any recent dental surgery or facial plastic surgery?

○ Yes ○ No

Do you have any uncontrolled heart conditions? (Uncontrolled heart rhythms, unstable angina, Heart Failure with EF <35%) PLEASE NOTE: *If you have a pacemaker, it is okay to go in the chamber as long as the pacemaker is rated for the pressure goals.

○ Yes ○ No

Do you have any uncontrolled lung conditions? (COPD / Emphysema, Restrictive Lung Disease / Pulmonary Fibrosis, Uncontrolled Sleep Apnea (or severe and untreated), Genetic lung diseases that cause air pockets (alpha anti-trypsin d/o), History of a spontaneously collapsed lung, Uncontrolled Asthma) PLEASE NOTE: **If you have a CONTROLLED lung condition, clearance from your treating physician is encouraged.**

○ Yes ○ No

Please mark any of the following conditions or symptoms that you are currently experiencing.

☐ Uncontrolled seizure disorder
_____

☐ Uncontrolled Hypertension with SBP >160 and DBP >11
_____

☐ Uncontrolled Diabetes
_____

☐ Uncontrolled Asthma
_____

☐ Fever > 100.4
_____

☐ Unable to communicate re: pain/pressure, etc.
_____

☐ Pregnant or think you may be

☐ Active smoker ☐ Previous smoker pregnant

_____ _____ _____

☐ None

_____

Do you have mild or severe claustrophobia?

○ Yes ○ No

Safety Precautions

Are you able to safely step into the chamber AND safely be seated on the cushion on the floor without assistance? If not please explain

○ Yes ○ No

Please review the following guidelines:

Prior to each HBOT session, staff will assess you for any health history changes and comfort during your session. No food, drink or gum is allowed while inside the chamber.

Clothing	No change of clothing required. Shoes must be removed. Pockets must be emptied.
Jewelry	Please remove any sharp pieces to avoid damage to chamber.
Makeup, Lotions, Hair Products	Okay to keep on, best if dry.
Glasses	Okay to keep on.
Electronics	Okay to bring in relatively low power electronic devices (phones, tablets, laptops, LLLT, neurofeedback devices).
Hearing aids	Remove prior to entry.

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HealthFit Mild Hyperbaric Oxygen Therapy Consent Form

Hyperbaric Oxygen Therapy (HBOT), has been reported to have beneficial effects for a wide range of conditions, without negative side effects that can be harmful to your health. 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.**

What To Expect:

Fullness in the ears or sinuses. You may experience pain in the ears or sinuses. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, 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 terminated. If this happens of if pain persists beyond the visit, we recommend that you consult your physician to evaluate and alleviate the situation before attempting another visit.

You will most likely experience "popping" in your ears similar to flying on an airplane. This is normal.

Detoxification. Mild hyperbaric oxygen therapy may assist the body to naturally detoxify and balance digestive flora. Although rare, and 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, etc. Although this is a natural process and continuing treatments may be of benefit to accomplishing a positive result. However, if symptoms persist, we recommend consulting your physician to evaluate the situation before attempting another visit.

You Should Not Perform Hyperbaric Oxygen Therapy Treatment If You Have Any Of The Following:

- Otic Barotrauma (Ear Drum Injury)
- Pneumothorax or Punctured Lung
- Pregnancy
- Significant Asthma
- Severe Claustrophobia
- Eustachian Tube Dysfunction
- Chronic Obstructive Pulmonary Dysfunction (COPD)
- Seizures
- Upper Respiratory Infection

*** If you are uncomfortable in any way, or have any questions during your treatment session, you need to report them to the chamber operator immediately. We are here to help you to have a pleasant and satisfying session.**

***Your safety is our priority. Patient must be able to safely enter and exit the hyperbaric oxygen chamber with minimal assistance.**

Electronics Inside HBOT Chamber

Relatively low power electronic devices (iPads, phones, LLLT, neurofeedback devices) are okay to bring inside the HBOT chamber, and caution is advised with laptops (ask manufacturer if pressure tested).

HealthFit is not responsible for any damages to electronics brought inside the HBOT chamber.

Responsibility for Damages

To ensure clients can enjoy a safe, comfortable and clean experience, the chamber is inspected by staff before and after each session. Patient is responsible for any damage to HBOT equipment and the interior or exterior of the chamber during their session. In the case that the equipment or chamber is damaged, a $500 damage/cleaning fee will be applied.

I, _____, acknowledge and consent to hyperbaric oxygen chamber treatment.

The undersigned hereby releases HealthFit, and its operators from all liability and responsibility whatsoever for personal injury, property damage or wrongful death however caused, including, but not limited to, the negligence, active or passive.

The nature and purpose of hyperbaric oxygen therapy has been explained to me and I hereby acknowledge that I understand the nature and purpose of these treatments. I understand that the practice of medicine is not an exact science and I have been made no promises or guarantees as to the results of hyperbaric oxygen therapy. Additionally, I acknowledge the possible risks and side effects of hyperbaric oxygen therapy, including but not limited to those listed above. I hereby understand that I am entering into hyperbaric treatment at my own risk. I have read this consent thoroughly and have had the opportunity to ask any questions relevant to this treatment. I hereby give my authorization and consent to the performance of Hyperbaric Oxygen Therapy by HealthFit.

_____ _____

Client Signature Date

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Patient Financial Responsibility

Thank you for choosing HealthFit for your health care needs. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial responsibility and appointment cancellation/rescheduling policies, which are as follows:

- The patient is ultimately fully responsible for the payment of all charges or fees for services provided, regardless of any contract of insurance, any action at court, any settlement, structured settlement, verdict or arbitration award which may be received or be due, or the course of outcome of any dispute regarding the same.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency).
- The patient is responsible for any costs associated with the collection of patient balances.
- The office charges a $30 fee for returned checks.
- **It is our policy to collect payment in full for Physical Therapy & Chiropractic service on the date rendered.**
- Packages expire 12 months after date of purchase and are **nonrefundable/nontransferable**.

- For Physical Therapy and Chiropractic Services: The patient (Under the age of 65 with PPO Insurance) will be provided a Superbill for self-submittal for potential reimbursement upon request.

No-Show/Late Cancellation Policy

Our office sets aside a specific amount of time for you and your doctor exclusively to incorporate personal 1-on-1 treatment sessions.

We will make every attempt to confirm your scheduled appointment with you 24 hours in advance via text and/or email alerts.

If you will be unable to make it to your set appointment, we kindly request for **AT LEAST** a 24-hour notice of cancellation or request for rescheduling. This allows us to offer the appointment slot to another patient on our waiting list. In the event of a late cancellation, late reschedule or no-show, a fee will be applied accordingly. Please see the following:

- **LESS** than a 24-hours notice of cancellation will result in a charge equal to **50%** of the scheduled service total cost.
- "No-Show" appointments that are missed without any given notice will be charged in **FULL**.
- Appointments made within the 24-hour period that need to cancel/reschedule, must be done so with **AT LEAST** 4-hours notice of scheduled appointment time or will result in a charge of **50%** of the scheduled service amount.

HealthFit reserves the right to settle cancellation/rescheduling fees, co-pays, deductibles, and any outstanding balances due with the patient's payment information on file.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form and Appointment Cancellation/Rescheduling Policy:

_____ _____

*To be signed by parent/legal guardian if patient is under 18 years of age.

_____ _____

Patient Signature Date

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HealthFit COVID-19 Safety Compliance Policy

HealthFit is taking all precautions to protect you and everyone here at the office. The following questions should be reviewed prior to EACH appointment in order to screen for health safety:

1. Have you had a fever or felt feverish in the last 72 hours?
2. Are you experiencing any respiratory symptoms, including a runny nose, sore throat, cough or shortness of breath?
3. Are you experiencing any new muscle aches or chills?
4. Have you experienced any new changes in your sense of taste or smell?
5. Does anyone in your household have any of the above symptoms?

I understand that I will be subject to the above screening questions prior to beginning each appointment. It is my responsibility to answer each question truthfully and to the best of my knowledge.

In the event that I answer YES to any of the above questions, I agree to notify the staff immediately.

_____

If you have been exposed to COVID-19 OR are experiencing any COVID-like symptoms OR test positive, we ask that you please wait to come in for:

- 5 days since exposure or since symptoms first appeared or since positive test, AND at least 24 hours with no fever (without fever reducing medication) AND other symptoms are improving

If you have been exposed to COVID-19 and are not experiencing symptoms, we ask that you wait:

- 5 days since exposure AND no symptoms reported during 5 day period, with a negative result from a COVID-19 test taken on Day 5

COVID-19 Vaccine Policy

The above policies apply, regardless of being unvaccinated or vaccinated.

I understand that HealthFit policies are subject to change as CDC guidelines update.

_____

_____ _____

Client Signature Date