NORTH CAROLINA HYPERBARICS and WOUND CARE

NEW PATIENT FORMS PACKET

Patient of North Carolina Hyperbarics,

This PDF contains patient forms you can fill out electronically or by hand.

If you decide to fill out the forms electronically, you can save them before printing them. There are information-only pages at the end of these forms. You do not need to print those for your visit.

We require you to bring your insurance card and a photo ID to your first appointment.

If you have an Advance Directive related to your health care, please bring a copy of all those documents to your first appointment.

Please do not email these forms back to us. Emailing these forms filled out to anybody, including us, using unencrypted email violates HIPAA (Health Insurance Portability and Accountability Act of 1996). In addition, you have personal information on these forms that can be stolen.

If you have any questions, call North Carolina Hyperbarics at 910-920-1165.
Thank you.

NORTH CAROLINA HYPERBARICS and WOUND CARE

3035A Boone Trail Extension
Fayetteville, NC 28304

910-920-1165
Fax: 910-425-5178

Visit our web site at www.NorthCarolinaHyperbarics.com

HYPERBARIC PHYSICIANS
OF NORTH CAROLINA

PATIENT REGISTRATION

Patient Information. (Please Print Legibly) **AT CHECK IN AT THE FACILITY, YOU WILL NEED YOUR INSURANCE CARD AND A PHOTO ID.**

Last Name	First Name, MI	Preferred Name	Date of Birth

Street Address	City	State	Zip Code

Home Phone	Cell Phone	Email Address

Leave a message with call back only ☐ Home ☐ Cell | Leave message with details ☐ Home ☐ Cell | Social Security #

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated | ☐ Female ☐ Male | Preferred Language

Race/Ethnicity ☐ Decline ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic/Latino ☐ Other:_____

Occupation ☐ Employed ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Student

Referring Physician	Primary Care Physician ☐ Check if Same as Referring

Preferred Pharmacy	Pharmacy Phone	Pharmacy City/State

Emergency Contact	Emergency Phone

Advanced Directive ☐ Yes ☐ No If yes provide a copy to the facility

How did you hear about us ☐ Physician Referral ☐ Internet/Website ☐ Former Patient ☐ Self Referred ☐ Word of Mouth ☐ Other _____

I authorize Hyperbaric Physicians of North Carolina and the Facility to release my information to the following individual(s):

NAME	RELATIONSHIP	PHONE
	☐ Spouse ☐ Parent ☐ Son/Daughter ☐ Friend ☐ Other_____	☐ Cell ☐ Home
	☐ Spouse ☐ Parent ☐ Son/Daughter ☐ Friend ☐ Other_____	☐ Cell ☐ Home

Responsible Party, If Other Than Patient. (Please Print Legibly) If *authorized representative must attach documentation of such status.*

Last Name	First Name, MI	Date of Birth	Relationship ☐ Parent ☐ Guardian ☐ Authorized Representative ☐ Other

Street Address	City/State/Zip Code	Phone ☐ Cell ☐ Home

Patient Insurance Information. (Please Print Legibly)

Primary Insurance Company	Member # (or Id #)	Group #

Policy Holders Name	Date of Birth	Relationship To Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policy Holders Address ☐ Check if Same as Patient | City/State/Zip Code

Secondary Insurance Company ☐ Not Applicable	Member # (or Id #)	Group #

Policy Holders Name	Date of Birth	Relationship To Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policy Holders Address ☐ Check if Same as Patient | City/State/Zip Code

ONLY IF WORKMAN'S COMP Patient's Employer		Street Address	
City/State/Zip Code	Work Phone	Insurance Carrier	Claim Number

I certify that the information provided is true and correct to the best of my knowledge. I will notify the FACILITY of any changes to the information immediately.

Signature of Patient or Parent/Guardian (If Minor) or Authorized Representative	Date	Staff Initials

HYPERBARIC PHYSICIANS OF NORTH CAROLINA
3035A Boone Trail Extension,
Fayetteville, NC 28304
910-920-1165 Fax: 910-425-5178

RESET FORM

HYPERBARIC PHYSICIANS
OF NORTH CAROLINA

PATIENT ACKNOWLEDGMENT & CONSENTS

Patient Last Name	Patient First Name, MI	Date of Birth

CONSENT FOR TREATMENT: I consent to all diagnostic and treatment procedures/examinations provided by HYPERBARIC PHYSICIANS OF NORTH CAROLINA (HPNC) and this FACILITY. This may include, but not be limited to injections, biopsies, administration of medications, treatments, and procedures considered medically necessary for the care of my medical condition . I understand that the procedures will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I consent to treatment and care provided by a team of healthcare providers, which may include physicians, mid-level providers such as physician assistants, Certified Hyperbaric Technologist, Certified Hyperbaric Registered Nurse, Diver Medic Technologist or advanced care practice nurse practitioners.

TELEPHONE CONSUMER PROTECTION ACT CONSENT: I expressly consent to receive telephone calls and text messages from HPNC and this FACILITY, its affiliates, agents, vendors or third parties calling or texting on its or their behalf at any number that I provide or that they may obtain from me. Such calls or texts may be made using an automatic telephone dialing system and/or prerecorded or artificial voice and may be made for any non-marketing purpose, including but not limited to: communications about my treatment, medication assistance, insurance benefits or account, appointment reminders, balance due and payment reminders, and debt collection attempts. I understand that text messages are not secured and may be accessed by unauthorized third parties. By authorizing the use of text message communications, I assume the risks of unsecure transmission of my health information. I understand this consent to communications is not required to receive services from HPNC or any other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time by providing written notice to this Facility.

PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS: I understand that physicians or staff may request to take photographs, videotapes, or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care, or treatment purposes. I grant permission to take medical photographs of my condition and hereby authorize the publishing or reproduction of such photographs for correspondence with my treating physicians and for teaching/educational purposes. I understand that I will not be identified by name and that my anonymity will be preserved in any presentation or publication. These photographs shall remain a permanent part of my patient record and are owned by HPNC. I understand that I have the right to request cessation of recording or photographing at any time.

PRIVACY PRACTICES: I acknowledge that I have been provided a copy of the Notice of Privacy Practices from HPNC and this FACILITY and that I have read (or had the opportunity to read if I so chose) the Notice of Privacy Practices. (Please Initial) _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENTS

ASSIGNMENT OF BENEFITS: If I am entitled to benefits under the Medicare program or any insurance policy or other health benefit plan, in consideration for services provided to me by HPNC and this FACILITY I assign, transfer, and convey the benefits payable under such program, policy, or plan for services rendered to HPNC and this FACILITY. I authorize payment of benefits directly to HPNC and this FACILITY, with such benefits applied to my bill.

PATIENT RESPONSIBILITY: I understand and acknowledge that the assignment of benefits does not relieve me of my financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, or not preauthorized by my insurance plan. I agree to provide all known insurance information at the time that services are rendered. If I overpay on my account, I authorize the application of such overpayment to satisfy any outstanding charges I owe for services rendered by HPNC and this FACILITY.

INFORMATION RELEASE: I authorize HPNC and this FACILITY to release all protected health information to my insurance, (including Medicare, if appropriate) and third-party collection agencies to secure payment for services rendered. I also authorize HPNC and this FACILITY to release my medical information to my Primary Care Physician, Referring Physician or Other Treating Physician for continuity of my care. I understand that HPNC and this FACILITY may access, use and disclose PHI for purposes of treatment, payment and healthcare operations without my further authorization and I may refer to the Facility's Notice of Privacy Practices located at www.northcarolinahyperbarics.com/forms/ for further information on the use and disclosure of my protected health information.

REFERRALS: I understand that it is my responsibility to obtain any referrals required by my insurance company from my primary care physician or insurance carrier. It is my responsibility to make sure that my referral is accurate and denial of payment because of my failure to do this will result in me being personally responsible for the charges incurred.

FAMILY AND MEDICAL LEAVE ACT/DISABILITY PAPER WORK FEE: $50.00 (Please Initial) _____

I have read the policies outlined above, and my signature below acknowledges a clear understating of the information and my responsibilities.

Signature of Patient/Parent/Guardian or Authorized Representative	Date	Staff Initials
Printed Name of Authorized Representative	**RELATIONSHIP TO PATIENT. If other than self.** ☐ Parent/Guardian ☐ Authorized Representative	

HYPERBARIC PHYSICIANS OF NORTH CAROLINA
3035A Boone Trail Extension,
Fayetteville, NC 28304
910-920-1165 Fax: 910-425-5178

RESET FORM

HYPERBARIC PHYSICIANS
OF NORTH CAROLINA

Your Partners In Healing

3035A Boone Trail Extension
Fayetteville, NC 28304

910-920-1165 Fax: 910-425-5178

AUTHORIZATION RELEASE MEDICAL RECORD

Please Print

Patient Last: _____ First: _____ MI: ____ DOB: _____

Home Phone: _____ Cell Phone: _____

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: _____ **Phone:** _____

Facility Address: _____ **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: _____ **Phone:** _____

Address: _____ **Fax:** _____

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

☐ **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 (3) three years 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

RESET FORM

RESET

NORTH CAROLINA HYPERBARICS and WOUND CARE

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INTAKE PATIENT DATABASE

Please Print Legibly

Date: _____

Patient Name Last: _____ First: _____ Middle Initial: _____

Date of Birth:_____ Race: _____ Primary Language: _____ ☐ Male ☐ Female

Referring Physician: _____Phone/Fax: _____

Primary Physician: _____Phone/Fax: _____

Other Physicians: _____Phone/Fax: _____

REQUIRED

Pharmacy: _____**Phone:** _____

Address/Street:_____

Home Health Agency: _____ Phone: _____

ALL MEDICATION

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

DRUG ALLERGIES

MEDICATIONS	Adverse Effect

YOUR MEDICAL DIAGNOSES

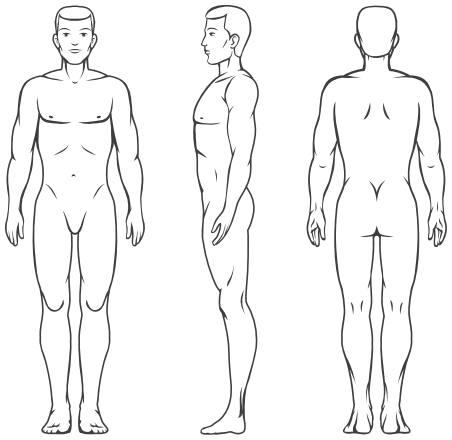
CURRENT OR PAST MEDICAL PROBLEMS

Approx. Date		Approx. Date	

PREVIOUS SURGERIES, OPERATIONS

☐ If you need more space, check the box and write on the back.

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



What is the location of your pain? _____

_____

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

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

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 _____

Is your Mother still alive? ☐ Yes ☐ No Age at Time of Death _____

If no what was the cause of death of your Mother? _____

Is your Father alive? ☐ Yes ☐ No Age at Time of Death _____

If no what was the cause of death of your Father? _____

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

_____ _____ _____ _____

DOB:_____

Last: _____ First: _____ MI:____

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☐			

DOB:_____

Last: _____ First: _____ MI:____

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)	Y☐	N☐
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☐	Hypercoagulable (Clotting Disorder)	Y☐	N☐			
Bruising	Y☐	N☐	Lymph-edema	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☐			

DOB:_____

Last: _____ First: _____ MI:____

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. Cisplatin	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

Reviewed By: _____ MD/DO Date _____

NORTH CAROLINA HYPERBARICS and WOUND CARE

North Carolina Hyperbarics, LLC
3035A Boone Trail Extension
Fayetteville, NC 28304
910-920-1165 Fax: 910-425-5178

NorthCarolinaHyperbarics.com

DOB:_____

Last: _____ First: _____ MI:____

NORTH CAROLINA
HYPERBARICS
and
WOUND CARE

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.

NORTH CAROLINA HYPERBARICS and WOUND CARE

North Carolina Hyperbarics, LLC
3035A Boone Trail Extension
Fayetteville, NC 28304

910-920-1165
Fax: 910-425-5178

Effective Dare: January 31, 2019

NCH10496_180206 HIPPA Booklet

Your Partners In Healing

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 the supervision of your primary physician.

HYPERBARIC
Administrative Services
1341 Canton Road, Suite A
Marietta, GA 30066
Phone: 770-422-0517
Fax: 678-638-7015

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