Hyperbaric Oxygen Therapy (HBOT) – Patient Intake Instructions

Thank you for choosing our facility for your Hyperbaric Oxygen Therapy (HBOT) care.
To ensure a smooth and timely start to your treatment, please review the requirements below.

ALL PATIENTS (Required for Everyone)

The following must be completed before scheduling or treatment:

- Completed Patient Intake Form
- Medical History / Recent Office Notes
- HBOT Prescription or Order (if available)

☐☐ Important:
Incomplete submissions will delay your treatment.
Your intake will NOT be processed until all required documents are received.

IF YOU ARE PAYING OUT OF POCKET (SELF-PAY)

To begin treatment, please provide:

- Completed Patient Intake Form
- Medical History / Recent Records
- Government-issued ID (Driver's License or Passport)

Once received, our team will contact you to schedule your treatments.

IF YOU ARE USING INSURANCE

To submit for insurance authorization, we require the following:

- Front & Back of Insurance Card(s)
- Front & Back of Government-issued ID
- Completed Patient Intake Form
- Medical History / Recent Office Notes
- HBOT Prescription / Physician Order
- ICD-10 Diagnosis Code
- Supporting Medical Documentation
- Proof of condition (e.g., wound reports, radiation history, clinical notes)

☐☐ Important:
If all required documents are not submitted, your treatment cannot be sent for insurance approval.

INSURANCE AUTHORIZATION PROCESS
Authorization typically takes 7–15 business days
Processing begins only after ALL documents are received
We will contact you once:
Authorization is approved, or
Additional information is required

☐ Please be patient during this process.

NEXT STEPS

✓ Submit your completed intake and all required documents
✓ Ensure all files are clear and legible
✓ Send documents via secure upload or email as instructed

IMPORTANT REMINDER
Incomplete intake packets will NOT be processed
Missing documentation will delay authorization and scheduling

Questions?
Our team is here to help guide you through the process.
info@pbhyperbarics.com

Hyperbaric Services of the Palm Beaches, LLC
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Suite H3 & 4
Delray Beach, FL 33484
561-819-6125
561-819-6127 Fax

INTAKE FORMS

Check list

- Drivers License/ Identification Card
- Insurance Cards
- Health Care Power of Attorney (if applicable)

Hyperbaric (HBOT) Clearance

- History & Physical
- Imaging Report-Only
- RX or Referral (if applicable)

Please sign and date
and *Must be completed

Email completed intake form to:
Info@pbhyperbarics.com

Hyperbaric Services of the Palm Beaches, LLC
International Institute for Brain Enhancement (IIBE)

5130 Linton Blvd Suite H3 & 4
Delray Beach, FL 33484
561-819-6125
561-819-6127 Fax

Patient Information

(Please Print)

Date: _____

Name: _____S.S # _____

Address: _____ Date of Birth : _____

City : _____ State : _____ Zip Code: _____

Home Phone : _____ Cell Phone :_____

Work Phone : _____E-mail Address : _____

Are you from out of town? ☐ Yes ☐ No If **Yes**, your local address and phone number

_____

Check Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Minor, Parent or Legal Guardian :

_____

Spouse's Name:

_____

Home Phone: _____ Work/Cell Phone : _____

Person Responsible for the Bill : _____

Address & Phone Number : _____

Employer, Address & Phone Number : _____

_____

_____

Is this patient covered by insurance? ☐ Yes ☐ No if **Yes**, Please indicate primary insurance information:

_____

_____

☐MEDICARE ☐HUMANA ☐AVMED ☐ AENA BCBS NH? ☐CIGNA WORKCOMP

Other : _____

Subscribers Name:_____ S.S # _____

Date of Birth: _____ Group # :_____Policy #:_____

Patient's Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:_____

_____

Secondary Insurance (If Applicable) _____

Subscriber`s Name:_____Date of Birth :_____

Group #: _____Policy #_____

Patients Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:_____

IN CASE OF EMERGENCY: Name of Local Friend or Relative
(not living at the same address)

Name: _____ Relationship : _____

Home/Work Phone:_____ Cell Phone: _____

(PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)

Physician Information

Physician's Name:_____

Address:_____

City:_____ State : _____ Zip Code : _____

Phone:_____ Fax : _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hyperbaric Services of the Palm Beaches, LLC Dr insurance company to release any information required to process my claims.

_____

Patient/ Guardian Signature Date

Info@pbhyperbarics.com

Hyperbaric Services of the Palm Beaches, LLC
5130 Linton Blvd Suite H3 & 4
Delray Beach, FL 33484
561-819-6125

I,_____hereby authorize Hyperbaric Services of the Palm Beaches LLC, to charge my credit card for the amounts invoiced.

VISA / MASTERCARD / DISCOVER

Credit Card Number:

_____Expiration Date:_____

Credit Card Billing Address:

Street: _____

Zip Code: _____

3 Digit Code on back of card: _____

Cardholders Signature: _____Date:_____

Your completion of this authorization form helps us protect you, our valued patients,from credit card fraud. Hyperbaric Services of the Palm Beaches, LLC will keep all information entered on this form strictly confidential.

Hyperbaric Services of the Palm Beaches, LLC

5130 Linton Blvd
Suite H3 & 4
Delray Beach, FL 33484
561-819-6125

CANCELATION, LATENESS AND FEE AGREEMENT

Due to our tight scheduling and personalized treatment plans, we kindly ask for a 24-hour cancellation notice. If you are calling outside of office hours, please leave a message with the answering service.

If you anticipate being late for your appointment, please notify us as soon as possible so we can make the best use of your scheduled time. Please note, if you are more than 10 minutes late for your appointment, your treatment session may be shortened.

No-Show Fee: A $25 fee will be charged for missed appointments or no-shows.

Frequent cancellations, lateness, or no-shows may result in the loss of your scheduled time slot.

Thank you for your understanding and cooperation.

I, _____ am the responsible party for payment to Hyperbaric Services of the Palm Beaches, LLC.

HIPAA Notice of Privacy Practices
Hyperbaric Services of the Palm Beach International
Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes B5, 113,Hs, & 18
Delray Beach, FL 33484

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS T) THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information' is information about, including demographics information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures_ of Protected Health Information

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:We may use or disclose, as needed, your protected health in formation in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call) you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement:
Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security:
Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, We must make disclosures to you the Secretary of the Department of Health and Human Services to investigate or determine our and when required by
compliance with the requirements of Section 164.500. INITIAL

INTITAL _____

HIPAA Notice of Privacy Practices

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure of indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action)r processing, and protected health information that is subject to law that prohibits access to protected health information You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and We may prepare a rebuttal t your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures We have made, if any, of your protected health information We reserve the right to change the terms of-his notice and will inform you by mail of- any changes You then have the right to object or withdraw as provided in this notice.

Complains
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes en-active on or before April. 14, 2003 We are required by Law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

INTITAL _____

Hyperbaric Services of the Palm Beaches, LLC
5130 Linton Blvd Suite H3 & 4
Delray Beach, FL 33484
561-819-6125

General Consent for Hyperbaric Treatment and Liability Disclaimer

The patient hereby consents to treatment with Hyperbaric Oxygen Therapy and related services(HBOT) provided by Hyperbaric Services of the Palm Beaches, LLC (HSPB). The patient acknowledges and understands that HBOT for patient's condition is not purported to be a standard therapy or cure; it is to be considered a supportive therapy only. HSPB does not make any other claims or benefits for the treatment of patient's condition.

The patient also understands that such treatment is not an exact science and that no guarantees have been made concerning the results or potential side effects of the proposed services. Further, HSPB cannot control all possible risks to or interactions with patient's other medical care, treatment or procedures outside of the HSPB facility

HSPB does not warrant or guarantee any results of the HBOT, and HEREBY EXPRESSLY DISCLAIMS ANY LIABILITY WHATSOEVER FOR ANY unanticipated effects or results of the HBOT services provided. In consideration for HBOT se_vices received, Patient voluntarily and knowingly agrees to release, hold harmless, indemnify, and forever discharge HSPB, its affiliates and related entities, and their representatives. agents, employees, physicians, contractors, officers, directors, members, successors and assigns (collectively, Released Entities"), from and against any and all liability, claims, suits, demards, any and all injury, or death arising out of or related to the HBOT services. including payment or causes of action for interest, and reasonable attorney's fees and costs

My signature below represents that I am competent to execute this agreement, that I have read and understand the above, was given the opportunity to discuss this form and have any questions answered, and knowingly consent to the conditions set forth above.

Patient :_____ Date :_____
(Name Printed)

_____
(Patients Signature)

Witness_____ Date :_____

Hyperbaric Servives of thr
Palm Beaches, LLC

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Hyperbaric Services of the Palm Beaches, LLC, may use and disclosed protected health information (PHI) about you to carry out treatment, payment and health care operation (TPO). Please refer to our notice of Privacy Practices or a more complete description of such disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time

With your consent, Hyperbaric Services of the Palm Beaches, LLC, may call your home or office and leave a message in reference to any items that assist the practice of carrying out TPO such as appointment reminders, insurance items and any calls pertaining to your clinical care.

With your consent, Hyperbaric Services of the Palm Beaches, LLC, may mail to your home or office any items that assist the practice of carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclosed your PHI to carry out treatment, payment and health care operations. However, we are not requested to agree to your requested restrictions, but if we do, we are bound by our agreement.

BY signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. IF YOU DECLINE TO SIGN THIS CONSENT, WE MAY DECLINE TREATMENT TO YOU.

Signature of Patient or Legal Guardian:_____

Patient's Name :_____

Date:_____

Print Name of Patient or Legal Guardian:_____

Authorization for Release of Information

Patient Name :_____ DOB :_____

_____, is authorized to release protected health information bout the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information
Check each person/ entity that you Approve to receive information

Description of Information to be released
Check each that can be given to person or entity on the left in the same section

Voice-mail/ cell phone

- ☐ results of lab tests/x-rays
- ☐ Other

Spouse (provide name/ phone number)

_____

- ☐ financial
- ☐ medical

Parent (provide name/ phone number)

_____

Friend (provide name/ phone number)

- ☐ financial
- ☐ medical

_____

I understand that I have the right to revoke this authorization at any time, I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing, This authorization shall be in effect until revoked by the patient.

_____

Signature of patient or personal representative Date

Hyperbaric Services of the Palm Beaches

Initial Learning Assessment

Name :_____

Date: _____

During your visit with our organization you will be presented with information that may be new to you. To aid in.providing the best care possible please answer the following questions.

How do you like to learn new things? Please check all that apply

	Reading		Picture/Diagrams
	Discussion		Hands On/ Demostration
	Videotapes		Self-Study

Factors that can affect learning:	Yes	No	Comments
Do you speak English in your home?			If no what languages do you speak? Name of interpreter :
Can you read English?			
Do you hear well?			If No, do you utilize a hearing device? ☐ YES ☐ NO
Do you see well?			If No, do you utilize a glasses or contact ? ☐ YES ☐ NO
Do you have any cultural or religious practice/ beliefs that may affect your care or treatment			If Yes, explain:

Other Comments: _____

_____

_____

_____

_____

_____

Hyperbaric Services of the Palm Beach
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes B5, H3, H4, & I8
Delray Beach, FL 33484
561-819-6125
561-819-6127 - Fax

Patient Medical History

Patient Name:_____ Date : _____

Diagnosis: _____ Date of Birth :_____

Referring Doctor: _____ Phone:_____

Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Aids or HIV Infection	☐	☐	Glaucoma	☐	☐	Malignant Disease	☐	☐
Anemia	☐	☐	Hay Fever/Allergies	☐	☐	Mitral Value Prolapse	☐	☐
Angina	☐	☐	Hepatitis/Jaundice	☐	☐	Neurological Disease	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐
Asthma Bronchitis	☐	☐	Heart Disease	☐	☐	Recent Weight loss	☐	☐
Cancer	☐	☐	Heart Murmur	☐	☐	Respiratory problems	☐	☐
Cardiac Pacemaker	☐	☐	Heart Problems	☐	☐	Rheumatic Fever	☐	☐
Chest Pains	☐	☐	Herpes	☐	☐	Rosacea	☐	☐
Claustrophobia	☐	☐	High Blood Pressure	☐	☐	Seizure Disorders	☐	☐
Cough - Chronic	☐	☐	Infections, Frequent	☐	☐	Stomach Problems	☐	☐
Diabetes	☐	☐	Joint Replacement/Implant	☐	☐	Stroke	☐	☐
Ear Problems/Surgery	☐	☐	Kidney Disease	☐	☐	Swollen Ankles	☐	☐
Emphysema	☐	☐	Liver Disease	☐	☐	Thoracic Surgery	☐	☐
Epilepsy/Convulsions	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Fainting/Seizures	☐	☐	Lung Disease	☐	☐	Ulcer	☐	☐
Frequently Tired	☐	☐	Lung Infection, Frequent	☐	☐	Wounds	☐	☐
			Lung, Shortness of Breath	☐	☐	Other	☐	☐

If yes, notes or comment:

_____

_____

_____

List of surgical procedures (procedure and date):

_____

_____

_____

Must be completed

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in medical treatment. I authorize Hyperbaric Services of the Palm Beaches DBA International Institute for Brain Enhancement (IIBE), to use photographs of me in educational presentations. I agree to be responsible for payment of all services rendered on my behalf or my dependents

_____

Signature of patient (Parent or guardian) Date

Hyperbaric Services of the Palm Beaches, LLC
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Suite H3 & 4
Delray Beach, FL 33484
561-819-6125
561-819-6127 Fax

Patient Name:_____Date:_____

Date of Birth:_____

List of Current Medications : ☐ NONE

_____

_____

_____

_____

List any Allergies to Medications: ☐ NONE

_____

_____

_____

_____

Must be completed

Hyperbaric Services of the Palm Beach
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes B5, H3, H4, & I8
Delray Beach, FL 33484
561-819-6125
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RELEASE FOR RECORDS

PATIENT NAME:_____

ADDRESS : _____

CITY :_____ STATE:_____ ZIP CODE : _____

CELL PHONE :_____

HOME PHONE :_____

DATE OF BIRTH :_____

I GIVE MY PERMISSION TO RELEASE RECORDS TO:

Hyperbaric Services of the Palm Beach
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes B5, H3, H4, & I8
Delray Beach, FL 33484
561-819-6125
561-819-6127 - Fax

☐ MEDICAL RECORDS ☐ RADIOLOGY STUDIES ☐ LAB TESTS ☐ EEGS ☐ TMS

☐ MANUFACTURE'S INFORMATION CARD FOR ANY IMPLANTED DEVICES

☐ OTHER :

_____

PATIENT SIGNATURE:_____

PATIENT PRINTED NAME :_____

WITNESS :_____ DATE:_____

Hyperbaric Services of the Palm Beaches
International Institute for Brain Enhancement (IIBE)
5130 Linton Blvd Stes H3,& H4,
Delray Beach, FL 33484

INFORMED CONSENT FOR HYPERBARIC OXYGEN TREATMENTS

1. I hereby authorize Hyperbaric Services of the Palm Beaches DBA IIBE and its practitioners to treat me with hyperbaric oxygenation therapy for the diagnosis of _____.

2. The procedure has been explained to me by Dr._____ and/or the hyperbaric personnel, including the risks and benefits of the procedure. I understand that I shall lie on a stretcher or sit in a hyperbaric chamber and breather oxygen at a greater than normal atmospheric pressure. I understand that each treatment will be for a prescribed amount of time and treatment may be terminated at any time I have also been made aware that possible risks and side effects of hyperbaric oxygenation include, but are not limited to:

   a. **Barotraumas or pain in the cars or sinuses**. I may experience pain in the ears or sinuses. I also understand that if I am not able to equalize my ears or sinuses that pressurization will be slowed or halted, and suitable remedies will be applied
   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 the chest cavity outside the lungs. This can only occurs if the normal passage of air out of the lungs is blocked during decompression. Only slow decompression is used in hyperbaric oxygen treatments to prevent 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 time than is known 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-nearsightedness.** (Myopia) After twenty or more treatments, especially if I am over forty; it is possible I may experience change in my ability to see things far away. I understand that this is usually temporary and that in the majority of patients, vision return as to its pre-treatment level six weeks after the completion 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. **Maturing or ripening cataracts**. In individuals with cataracts it has occasionally been demonstrated that there may be maturing or ripening of the cataracts.

g. **Temporary improvement in farsightedness**. (Presbyopia) After twenty or more treatments especially if I am over forty, there is a possibility that I may experience an improvement in my ability to see things close by cr to read without reading glasses. I understand that this is temporary and that in. the majority of patients, vision returns to its pre-treatment level about six weeks after the completion of treatments. I have been cautioned not to be fitted for new eye wear prescriptions for eight weeks after the end of my treatment .
h. **Numb fingers.** A small portion of patients sometimes notice a numb feeling in the fourth and fifth fingers of the hands after twenty Cr more treatments. This should not be of concern and should disappear in about six weeks following completion of treatments,
i. **Serous Otitis.** Fluid in the ears sometimes accumulates as a result of breathing high concentration of oxygen. I may occasionally feel like I have a "pillow on my car." This disappears after hyperbaric treatments cease and often can be eased with decongestants.
j. **Fatigue.** Some people may randomly feel fatigue following hyperbaric treatments, but this is not a consistent feeling,

4. I hereby authorize Hyperbaric Services of the Palm Beaches DBA IIBE or their employees to take medical photographs for the purpose 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.
5. 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
6. The staff of Hyperbaric Services of the Palm Beaches DBA IIBE has informed me that smoking cigarettes, pipes, cigars or any other form of tobacco products including chewing tobacco will result in the ingestion of chemi-als into the body, which may affect the efficacy, and success of the hyperbaric treatment. I have been specifically told not to smoke during the entire duration of my treatments
7. I consent to the release of information and/or disclosure of any part of my medical record by any physician, hospital, accreditation, oversigh: review or regulatory organization responsible for monitoring or evaluation health facilities as well as any other facility of which I have been a client.

My signature below constitutes my acknowledgement that I have read and agree to the foregoing and a physician has satisfactorily explained that hyperbarie o<ygen therapy to me and that I have all the information that I desire. I hereby understand that I am. entering into hyperbaric treatment at my own risk, and I hereby give my authorization and ccnsent to performance of hyperbaric oxygen therapy by Hyperbaric Services of the Palm Beaches DBA IEE,

Signature of Patient or Authorized Representative:_____

Witness to Signature: _____Date : _____

Submit/Upload all documentations to:**info@pbhyperbarics.com**

Hyperbaric Services of the Palm Beaches, LLC
5130 Linton Blvd Suite 3 & 4
Delray Beach, FL 33481
561-819-6125

Dear Patient and Family,

We look forward to you starting your treatments at our facility. There are several safety measures that will be followed. Each patient must wear 100% cot: on into the chamber, no buttons, snaps, Velcro and/or iron ons are not allowed. If you do not have clothing that is 100% cotton the facility will supply you with them during your treatment. A disposable diaper may be worn but must be covered by cotton pants or shorts.

Anyone going into the chamber for treatment must not have on:

Ointments	Hairspray
Hair Accessories	Deodorant
Dentures	Perfume
Hearing Aids	Mousse
Nail Polish	Hair Gel
Contact Lenses	Make Up
Jewelry	Lotions

NO toys, books or magazines are allowed in the chamber. A pacifier or clear bottle is allowed.

Due to the HIPPA Privacy Act we are unable to allow family members to stay in the hyperbaric room while the patient is being treated.

Patients should not drink any carbonated drinks at least one hour, if not more, prior to treatment, as it may cause stomach upset. A well balanced meal prior to your treatment is recommended, with the exception of patients with all types of feeding tubes, they must be fed no less than two hours before treatment time. Flying is not recommended 24 hours pre and post treatment. If the patient has a temperature of 101 degrees or higher they will not be treated

Our patient safety, comfort, and privacy are this facility's top priority.

I have read the above statements and agree to abide by them

Name:_____ Date :_____

Submit/Upload all documentations to:**info@pbhyperbarics.com**