Brevard Regional Hyperbaric Center

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

Patient Registration

Patient Name: ________________________________ SSN: ________________ DOB: _________

Address: ____

City: _____________________________________ State: _____________ Zip: _______________

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________

Email Address: ____

Sex: M F Marital Status: M D W S Living Will: YES NO Copy On File: YES NO

Ethnicity: Hispanic or Latin NON-Hispanic or Latin Primary Language: ___________________
Race: ___________________
Employment Status: Full-Time Part-Time Self Employed Retired Disabled Not Employed

Employer Name: ____

Student Status: Full-Time Student Part-Time Student Not a Student Race: _________________

Emergency Contact Name: ________________________________ Relationship: ______________

Emergency Contact – Home Phone: ___________________ Cell Phone: _____________________

Primary Care Physician: ______________________________ Phone: ________________________

Referred Physician: __________________________________ Phone: ________________________

Insurance Information

Primary Insurance: ________________________ Policy ID: ______________________________

Subscriber Name/DOB: _____________________ Group#: _______________________________

Secondary Insurance: ________________________ Policy ID: _____________________________

Subscriber Name/DOB: _____________________ Group#: _______________________________

Brevard Regional Hyperbaric Center

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

HIPAA FORM

Patient authorization for use and disclosure of Protected Health Information (PHI)

By signing, this authorization permits Brevard Regional Hyperbaric Center to use and/or disclose the following individually identifiable health information, PHI about me. I authorize release of following information to:

Name: ____________________________________ Relationship: _______________________________

☐ Medical Information ☐ Test Results ☐ Demographics ☐ Billing Information

☐ Appointment Information ☐ Any/All Information

Name: ____________________________________ Relationship: _______________________________

☐ Medical Information ☐ Test Results ☐ Demographics ☐ Billing Information

☐ Appointment Information ☐ Any/All Information

Name: ____________________________________ Relationship: _______________________________

☐ Medical Information ☐ Test Results ☐ Demographics ☐ Billing Information

☐ Appointment Information ☐ Any/All Information

The information will be used or disclosed for the following purpose:

If the disclosure is requested by the patient, purpose may be listed as “at the request of the individual.”

The purpose(s) are provided to me so that I can make an informed decision whether to allow the release of the information.

The Practice may receive payment or other remuneration for a third party exchange for using or disclosing the PHI.

PATIENT RIGHT TO PRIVACY: I understand that my medical information will only be released to myself, my doctors and my designated insurance company unless specifically directed by me above. I understand that the “Notice to Privacy Practices” brochure is available for my review. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the privacy officer at 1698 W. Hibiscus Blvd Suite B, Melbourne, FL. 32901.

Signature of Patient: ____ Date: ____________________

Print Patient Name: ____

Brevard Regional Hyperbaric Center

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

CONSENT TO TREAT

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

Initial Each Agreement

____ **1.** AUTHORIZATION TO TREAT: The undersigned authorizes any treatment(s), agreed upon with the physician which may be deemed advisable. This MAY include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, or other services rendered to the patient under the general or special instruction of the patient's physician.

____ **2.** ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: In consideration of services rendered, I hereby transfer and assign Paul W. Buza, DO all rights, title and interest in any payment due to me for services described herein as provided in the above mention policy or policies of insurance.

____ **3.** FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned should pay reasonable attorney's fees and collections expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

____ **4.** MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me.

____ **5.** I permit one copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic.

____ **6.** I understand that certain insurance claims may be filed as COURTESY. However, if the claim is denied for any reason, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I UNDERSTAND AND IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR MY INSURANCE OR THIRD PAYOR WITH A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

Patient Signature: ____ Date: _________________________

Print Patient Name: ____

Brevard Regional Hyperbaric Center

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

PATIENT HISTORY

Today's Date: ___________________________ Patient DOB: _____________________

Patient Name: ____

HISTORY OF PRESENT ILLNESS

Site of Radiation: ____

Centigray Units of Radiation: ________________ Have you received chemotherapy? YES NO

Type of Chemo received: __________________________________ When? ____________________

Radiation/Oncologist: ____

Location of Wound(s): _____________________________________ Age of Wounds: ____________

Diabetic: YES NO Insulin: YES NO Type: ______________________________________

Do you test your blood Sugar? YES NO How often? ________________________________

Who manages your diabetes? ____

Are you needing extractions? YES NO Is this surgery scheduled? YES NO

Scheduled date: ___________________________ Surgeon: _________________________________

Is HBOT needed for reconstruction? YES NO Is this surgery scheduled? YES NO

Scheduled date: ___________________________ Surgeon: _________________________________

Have you been told you have a bone infection (osteomyelitis)? YES NO

Have you received a bone scan or MRI confirming osteomyelitis? YES NO

Where was the above testing done? ____

Are there any other surgeries pending due to the healing of this wound and/or HBOT? YES NO

What surgery? ______________________________ Schedule: _______________________________

Surgeon: ____

Brevard Regional Hyperbaric Center

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

Patient Name: ____ DOB: ____________________

Pharmacy: __________________________________Location/Phone: __________________________

ALLERGIES

Drug Name Reaction

____

____

____

Are you currently taking any blood thinners? YES NO Type: ___________________________

MEDICATIONS

Drug Name Dosage How Often Prescribed by

____

____

____

____

____

____

____

____

____

Over the counter/Non-prescription drugs:____

____

Patient Provided Copy of Medication List. Did Staff Scan List? **YES NO**

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

Brevard Regional Hyperbaric Center

MEDICAL HISTORY

When was your last chest x-ray? ________________________ Where? ________________________

When was your last EKG? _________________________ Where? ____________________________

Do you smoke? **YES** __________ # Packs/Day **NO** Date Quit ____________________________

Do you drink alcohol? **YES** Qty/Frequency: _______ per week **NO** Date Quit __________________

Do you use recreational drugs? **YES** **NO** Type: ___________________ How often? _______________

Occupation: ___________________________________ Employer: ___________________________

Past Surgeries (Please list type of surgery, date of surgery and where the surgery took place):

____

____

Do you have a pacemaker, defibrillator or pump? YES NO

Family History

	FATHER	MOTHER	SIBLINGS	PATERNAL GRANDPARENTS	MATERNAL GRANDPARENTS
Living					
Deceased Cause/Death					
Age of Death					
Cancer (Type)					
Diabetes					
Heart Attack					
Stroke					
PVD					
COPD					
TB					
Seizure Disorder					

Other Problems:

____

____

Paul W. Buza, D.O., A.C.N., A.M.E.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639
Tel: (321) 676-3200 Fax: (321) 802-5101

Brevard Regional Hyperbaric Center

MEDICAL HISTORY

Patient Name: ____ DOB: ___________________

PLEASE PROVIDE A ✓ TO ALL THAT APPLY TO YOU - *PLEASE ONLY MARK THE CONDITIONS THAT ONLY YOU HAVE BEEN DIAGNOSED WITH*

✓	**Neurology**
	Seizure Disorder or Epilepsy
	Dementia
	Alzheimer's
	Parkinson's
	Neuropathy
	Stroke or TIA
	Sudden Blindness
	Carotid Stenosis
	Psychology
	Anxiety
	Depression
	Claustrophobia
	PTSD
	Hallucinations
	Cancer
	Type: Site:
	Type: Site:
	Type: Site:
	Nephrology
	Hypothyroidism
	Hyperthyroidism
	Goiter
	Diabetes Type I or II
	End Stage Renal Disease (ESRD)
	Urology
	Urinary Incontinence
	Frequent Urination
	Trouble Urinating
	Burning or Pain when Urinating

✓	**Vascular Disease**
	Peripheral Vascular Disease (PVD)
	Claudication
	Thrombosis
	Embolism
	Aneurysm
	Leg and/or Foot Pain at Rest
	Venous Stasis
	Lymphedema
	Leg and/or Foot Ulcer
	Cardiology
	Heart Attack
	Angina
	Atrial Fibrillation
	Murmur
	Irregular Heart Beat
	Congestive Heart Failure (CHF)
	Hypertension
	Hypotension
	Coronary Artery Disease (CAD)
	Coronary Heart Disease (CHD)
	Rheumatic Heart Disease
	Pulmonary
	Asthma
	COPD
	Tuberculosis
	Emphysema
	Bronchial Spasms
	Pneumothorax (Spontaneous or Traumatic)
	Pneumonia

✓	**ENT**
	Tinnitus
	Chronic Sinus Infections
	Chronic Ear Infections
	Reactive Airway
	Allergies
	Sudden Hearing Loss
	Eyes
	Sudden Loss of Vision
	Wears Glasses or Contacts
	Cataracts
	Macular Degeneration
	Spontaneous Retinal Detachment
	Gastrointestinal
	Ulcers
	GERD
	Hiatal Hernia
	Diverticulitis
	Ulcerative Colitis
	Crohn's
	Gallstones
	Constipation
	Diarrhea
	IBS
	Hepatitis __ A __ B __C
	Celiac Disease
	Cirrhosis
	Hematology
	Anemia
	Bleeding Disorders
	Auto Immune & Immuno
	Lupus
	HIV or AIDS