Brevard Regional Hyperbaric Center
Paul W. Buza D.O., FA.C.N.
1698 W. Hibiscus Blvd Suite B
Melbourne, FL 32901-2639

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 **Ethnicity:**_____

Sexual Ordination: Straight Bisexual Lesbian/Gay Don't Know Choose Not to Define Other (Please Describe) _____

Primary Language: English, Spanish, Other_____

Employment Status: Full-Time Part-Time Self Employed Retired Disabled Not Employed

Employer Name: _____

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: _____ **Group#:** _____

Secondary Insurance: _____ **Policy ID:** _____

Subscriber Name: _____ **Group#:** _____

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MEDICAL HISTORY

When was your last chest x-ray? _____ **Where?** _____

When was your last EKG? _____ **Where?** _____

Do you smoke? If YES, then ____ # Packs/Day If NO, then Date Quit _____

Do you drink alcohol? If YES, then ____ # Packs/Day If NO, then Date Quit _____

Do you use recreational drugs? YES NO Type: _____ How often? _____

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:

_____

_____

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HISTORY OF PRESENT ILLNESS

Cancer Survivors Only

Site of Radiation: _____

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

Type of Chemo received: _____ **When?** _____

Radiation/Oncologist: _____

Are you needing extractions/reconstruction? YES NO **Surgeon:** _____

Problems associated with radiated area: _____

Wound Care Only

Location of Wound(s): _____ **Age of Wounds**: _____

Cause of Wound:_____

Diabetic: YES NO **Insulin:** YES NO **Type:** _____

Do you test your blood Sugar? YES NO **How often?** _____

Who manages your diabetes? _____

Bone Infections – Osteomyelitis

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? _____

Have you completed 1 round of antibiotics to treat your bone infection? YES NO

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MEDICAL HISTORY

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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

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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:_____

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Patient HIPAA/PHI and Rights and Responsibilities

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 ☐ Billing Information ☐ Appointment Information ☐ Any/All Information

Name: _____ Relationship: _____

☐ Medical Information ☐ Test Results ☐ Billing Information ☐ Appointment Information ☐ Any/All Information

Name: _____ Relationship: _____

☐ Medical Information ☐ Test Results ☐ 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.

HIPPA Form: Patient Privacy Rights – You have the Right to:

- Inspect and request a copy of your medical record and other health information. You may submit a written request to our office and pay the copy fee and receive a copy of your records. We must respond within 30 days of your written request if the record is readily available and 60 days if it is not.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office and we must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last 6 years, starting January 4, 2016. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not super cede the typical disclosure noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy for this notice at new patient admission and by request.
  Our responsibilities under HIPAA:
- We are required by Law to maintain the privacy of your personal health information and to provide you notice of our legal duties and privacy practice and adhere to this notice.
- We reserve the right to make changes to this notice. We will post notice that a change has been made to the privacy policy and the effective date of the change. Copies will be available after the changes are made.

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- You can complain about your privacy or its execution, either verbally or in writing, to our Office Manager: Deborah Buzal, Administrator of Brevard Regional Hyperbaric Center, 1698 W. Hibiscus Blvd. Suite B, Melbourne, FL 32901 or by phone 321-676-3200.
- If you feel you have not achieved resolution you may contact the Secretary of Health and Human Services of the United States Government at www.hhs.gov/ocr.

Effective Date: January 4, 2016

I have read and understand my Rights to Privacy under the Laws of HIPAA.

Patient/Client Signature Date

Witness Signature Date

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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: _____

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Authorization to Disclose Health Information

Patient Name: _____ Date: _____
DOB: _____ SSN: _____ Telephone: _____
Address: _____

☐ **I authorize and request Brevard Regional Hyperbaric Center to release Medical Records to:**
Person or Organization: _____
Phone: _____ Fax: _____
Address: _____
Purpose: ☐ Personal ☐ Treatment/Continuation of Care ☐ Legal ☐ Medical/Surgical Clearance
☐ Transfer/Reason: _____ ☐ Other: _____

☐ **I authorize and request Brevard Regional Hyperbaric Center to OBTAIN Medical Records from:**
Organization: _____
Phone: _____ Fax: _____
Address: _____
For the PURPOSE of Continuation of Care.
Please ☐ Fax ☐ Mail the following information from my medical record for care and/or treatment:
☐ Office and Progress Notes ☐ Procedure/Surgery Reports ☐ Chest X-ray(s)
☐ Radiation Reports (including SI units of Radiation and Location) ☐ Diagnostic Studies
☐ Lab/Blood Work ☐ Other: _____
From the time period of _____ thru _____ / Present.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to disclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment by BRHC is in no way contingent on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that I used or disclosed.
- I understand that the 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.
- I understand that this authorization will remain in effect for **90 DAYS** or until I revoke it in writing to the Health Information Management Dept.

Patient Signature: _____ Date: _____
(Required for all patients 18 years and older)

Signature of Parent or Legal Guardian: _____ Date: _____
(Required for all patients under 18 years of age unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied.)

Brevard Regional Hyperbaric Center Fax: (321) 802-5101