20 Joy Drive, Suite 100 – South Burlington, VT 05403 - (802)863-5828 - info@cwnhc.com

Please fill out completely and answer all questions to the best of your ability.

Name_______________________________________ Date_____________________________

Address_____________________________________ Home Phone ______________________

City_________________State_______Zip _________ Business Phone _____________________

Email ______________________________________ Cell Phone _________________________

Date of Birth________________ Age____ Occupation ___________________________________

How did you hear about Cedar Wood Natural Health Center? ______________________________________

Referring Physician ____________________________

Address_____________________________________ Phone ____________________________

City_________________State_______Zip _________

Additional Physician ____________________________

Address_____________________________________ Phone ____________________________

City_________________State_______Zip _________

What is the reason you seek Hyperbaric Oxygen Therapy? ____

____

Medical History and Medications

Are you currently undergoing medical treatment? Please describe. __________________________________

____

If you exercise on a regular basis, how frequently? ____

If you use tobacco, how frequently? ____

If you use alcohol, how frequently? ____

Are you pregnant or think you may be pregnant? ___No ___Yes

./.

Have you ever had any ear problems? ! No ! Yes Please describe. ________________

Do you have any problems with your ears when you fly? ! No ! Yes

Are you currently prescribed or taking any of the following medications? Check all that apply.

- ! Bleomycin
- ! Cis-Platinum
- ! Disulfiram (Antabuse)
- ! Doxorubicin (Adriamycin)
- ! Mafenicide Acetate (Sulfamylon)

Have you ever had or been suspected of having any of the following conditions? Check all that apply.

- ! COPD
- ! Hereditary Congenital Spherocytosis
- ! Severe Emphysema
- ! Sickle Cell Anemia
- ! Untreated Pneumothorax

Have you ever had radiation therapy? ! No ! Yes Please describe. ________________________

Have you had or do you currently have any of the following?

- ! Acute Respiratory Illness
- ! Allergies
- ! Anemia
- ! Angina/Chest Pain
- ! Anxiety
- ! Arthritis
- ! Aspergers/Autism
- ! Asthma
- ! Back Pain
- ! Bells Palsy
- ! Cancer or Malignant Tumor
- ! Cataracts
- ! Chemical sensitivity
- ! Chemotherapy
- ! Chronic Back Problems
- ! Chronic Bronchitis
- ! Chronic Fatigue
- ! Claustrophobia or Panic Attacks
- ! Congenital Spherocytosis
- ! Crohns Disease
- ! COPD/Lung Disease
- ! Dentures
- ! Diabetes Type 1
- ! Diabetes Type 2
- ! Ear Infections (frequent)
- ! Ear Trauma
- ! Emphysema
- ! Epilepsy or Seizure Disorder
- ! Exposed Bone
- ! Fainting
- ! Fever – current
- ! Fibromyalgia
- ! Glaucoma
- ! Heart Attack
- ! Heart Disease/Heart Problems
- ! Heart Failure
- ! Heart Murmur
- ! Hepatitis/Jaundice
- ! Herpes
- ! High Blood Pressure
- ! HIV Infection/AIDS
- ! Infections (frequent)
- ! Kidney Disease
- ! Leukemia
- ! Liver Disease
- ! Low Blood Pressure
- ! Lung Infections (frequent)
- ! Lyme Disease
- ! Malignant Disease
- ! Mitral Valve Prolapse
- ! MRSA (Staphylococcus)
- ! Multiple Sclerosis
- ! Neurological Disease
- ! Optic Neuritis
- ! Pneumothorax/Collapsed Lung
- ! Pregnant – current
- ! Pulmonary Cysts or Abscesses
- ! Radiation Therapy

- ❢ Recent Dental Surgery
- ❢ Recent Weight Loss
- ❢ Respiratory Problems
- ❢ Rheumatic Fever
- ❢ Ringing in the Ears
- ❢ Rosacea
- ❢ Sinusitis
- ❢ Sleep Apnea
- ❢ Stomach Problems/Ulcers
- ❢ Stroke
- ❢ Swollen Ankles
- ❢ Thoracic Surgery
- ❢ Thyroid Problems
- ❢ Traumatic Brain Injury
- ❢ Tuberculosis
- ❢ Upper Respiratory Infection
- ❢ Viral Infection – current
- ❢ Other ______________________________

Please list types of surgeries and dates.

Type of surgery:	Date:
____	______________________
____	______________________

Have you been hospitalized for any serious illnesses within the last 5 years?

❢ No ❢ Yes Please describe. Include dates. ____

____

____

Are you taking any medications (prescription or over-the counter)? ❢ Yes ❢ No

List medication(s):	To treat:	Duration/For how long?
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Were you previously taking any medication regularly? ____

Please list current allergies. ____

I certify that all of the information above is true and accurate. I **agree to advise Cedar Wood Natural Health Center of any changes in my patient information, medical status, medications, allergies, or any other information** concerning my therapy.

I have reviewed the Cedar Wood Natural Health Center's Consent Agreement. I acknowledge the possible, but rare, side effects as indicated and am aware of contraindications to oxygen therapy. I also understand my responsibilities as a Cedar Wood Natural Health Center patient in terms of preparing for my therapy sessions.

I have reviewed the fee schedule and understand that I am responsible for payment on the date of service.

Signature ____ Date _________________________

CONSENT TO TREATMENT OF A MINOR

I hereby authorize staff at Cedar Wood Natural Health Center to administer mild hyperbaric oxygen therapy to

____.

Guardian's Signature _______________________ Date __________ Witnessed by _____________________

Consent For Use or Disclosure of Health Information

Our Privacy Pledge

Cedar Wood Natural Health Center is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

We may send you correspondence in the form of postcards, birthday cards, thank you letters, health information, newsletters, and other information. We may also send gift certificates for referring others patients to us. You have the right to refuse such correspondence.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy practices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

We may need to use your name, address, phone #, e-mail, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

____ Print Name	____ Authorized Provider Representative
____ Signature	____ Date
____ Date	