Hyperbaric Centers of Florida
21st Century technology in a safe and caring environment

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT FOR TREATMENT AND PAYMENT RESPONSIBILITY

I consent to care and treatment by **Hyperbaric Centers of Florida, LLC**, as may be prescribed by same and/or dictated by professional standards. The nature, purpose, benefits, and risks of all care and service have been explained to me. I authorize the release of patient health information (PHI) in order to carry out the treatment, payment of healthcare operation (TPO) to the practice of **Hyperbaric Centers of Florida, LLC.** Treatment includes the provision, coordination or management of healthcare form one provider to another. Payment means the activities conducted by the practice to obtain reimbursement for healthcare services. This includes, among others, billing, claims management, collection activities, verification of insurance coverage, and pre-certification of services. If I am person different from the patient, this authorization is on the patient's behalf and is permission to use a copy of this authorization in place of the original.

Payment is expected at time of service. We will provide an invoice if you wish to file it with your insurance.

AT THIS TIME, MEDICARE-MEDICAID AND MOST INSURANCE CARRIERS WILL ONLY COVER THE CURRENT APPROVED 15 INIDICATIONS. OUR TREATMENTS ARE CONSIDERED "OFF LABEL" AND "ALTERNATIVE" AND THERFORE ARE PAID OUT OF POCKET.

WE ACCEPT, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER. CREDIT CARE, CHECK AND CASH.

OUR RATE SHEET IS PROVIDED AND IS BASED ON WHICH CHAMBER YOU CHOOSE TO USE, THE LENGHT OF TREATMENT AND THE NUMBER OF TREATMENTS YOU DO.

Patient Name: _____

Name of person responsible for payment: _____

Signature of Person responsible for payment: _____

Date: ____/_____/_____