Hyperbaric Centers of Florida

21st Century technology in a safe and caring environment

PATIENT REGISTRATION FORM

Date of Contact: _____/______/______ Origin:________________Inquirer's Name:_________________

Patients Name:___________________,________________________Birth Date:_____/_______/______

Last First Middle

Street

Address____

City:__________________________State:________________Country___________Zip_______________

Home Phone:_____-______-________ Work:_____-_______-_________ Fax:______-______-_____

Cell Phone:______-_______-________ E-Mail____

Social Security No:_____/______/_______Driver's License No:__________________ State:___________

Marital status: Single__ Married__Widowed__Separated__Divorced__Other____________Sex: M__ F___

Emergency Contact:_________________ Relationship:_______________ Phone:_____-______-_______

Referred by:__________________Dr.__Friend__Other________________Phone:_____-______-_______

PRIMARY PARTY/PRIMARY INSURED (If not Patient) C

Name:__________________________,________________________Relationship__________________

Street

Address:(If different from patient's):____

City:___________________________State:__________Zip Code:__________Phone:_____-_____-____

Insurance Co:____________________________Policy No.:_______________Phone:_____-_____-____

Address:____________________________City:_________________State:_____ZipCode:____________

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT FOR TREATMENT

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 and related services by one of\r more healthcare providers, or the referral of a patient for healthcare from 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 a 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.

FINANCIAL AND MEDICARE POLICIES

PAYMENT IS EXPECTED AT TIME OF SERVICE. We provide the required form to attach to your insurance claim when filed.

We accept **VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER.**

MEDICARE POLICY: If **Hyperbaric Centers of Florida, LLC,** determines that the services provided do

not meet the requirements for coverage under Medicare, I verify that I received a MEDICARE WAIVER informing me of this possibility. As a non-participating Medicare provider, patients are charged the limiting charge for covered services at the time rendered. Non-covered services will be charged at our standard office rates.

____ ______/_______/_______

Signature Date