Please tell us a little about yourself so that we can achieve our goal of providing you with optimal care.

ABOUT YOU

Today's Date:_____

First Name:_____

Last Name:_____

E-Mail:_____

Birth Date:_____

Age:_____ ▢ Male ▢ Female

Home Address:_____

_____

CITY STATE ZIP

▢ Single ▢ Married ▢ Divorced ▢ Widowed

Home #:_____

Cell #:_____

Work #:_____

Employer:_____

Employer Address:_____

_____

CITY STATE ZIP

Occupation:_____

Emergency Contact Name:_____

Emergency Contact #:_____

By naming an emergency contact you authorize our office to speak to this person regarding your personal health information

Reason for Treatment:_____

Who referred you?_____

▢ Physician ▢ Friend ▢ Yelp ▢ Google ▢ Radio ▢ Magazine

Primary Physician's Name:_____

Primary Physician's Phone #:_____

MEDICAL HISTORY

Are you experiencing any of the following problems?

Y	N		Y	N	
◯	◯	Skin Cancer or Melanoma	◯	◯	Optic Neuritis
◯	◯	Keloids / Excessive Scarring	◯	◯	Heavy Periods
◯	◯	Cold Sores / Herpes	◯	◯	Cramping When Walking
◯	◯	Headaches / Migraines	◯	◯	History of Blood Clots
◯	◯	Numbness / Tingling	◯	◯	Trouble Swallowing
◯	◯	Seizures	◯	◯	Nausea / Vomiting
◯	◯	Nerve Palsy	◯	◯	Heartburn / Ulcers
◯	◯	Double Vision / Dry Eyes	◯	◯	Malignant Hyperthermia
◯	◯	Easy Bruising / Bleeding	◯	◯	Neck Problems or Surgery
◯	◯	Anemia	◯	◯	Abdominal Pain
◯	◯	Chronic Cough/Respiratory	◯	◯	Constipation / Diarrhea
◯	◯	Infection of any kind	◯	◯	Depression / Anxiety / OCD
◯	◯	TB (Tuberculosis)	◯	◯	Schizophrenia
◯	◯	Breathing Difficulty / Asthma	◯	◯	Manic Episodes / Bipolar
◯	◯	On CPAP / Sleep Apnea	◯	◯	Body Dysmorphic Disorder
◯	◯	Chest Pain / Palpitations	◯	◯	AIDS / HIV
◯	◯	Heart Murmur/Valve Problem	◯	◯	Hepatitis A / B / C
◯	◯	Pacemaker / Defibrillator	◯	◯	Excessive Weight Gain / Loss
◯	◯	Breast Pain or Lumps	◯	◯	Skin Infections / MRSA
◯	◯	Untreated Pneumothorax	◯	◯	Congenital Spherocytosis

Please list all of your medical illnesses
(diabetes, hypertension, heart disease, lung disease, etc.)

▢ Check here if you have no Past Medical History

_____

_____

_____

_____

_____

_____

FOR WOMEN ONLY

Y	N	
◯	◯	Are you, or might you be pregnant?
◯	◯	Are you on birth control?

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING

▢ Check here if you are taking no medications

_____

_____

_____

_____

24 hour notice is required for any cancellation of scheduled appointments without exception.

ACCIDENT WAIVER AND RELEASE OF LIABILITY

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THIS EVENT, including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.
I certify that I am physically fit, have sufficiently prepared or trained for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no health-related reasons or problems which preclude my participation in this activity.
I acknowledge that this Accident Waiver and Release of Liability Form will be used by the event holders, sponsors, and organizers of the activity in which I may participate, and that it will govern my actions and responsibilities at said activity.
In consideration of my application and permitting me to participate in this activity, I hereby take action for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

A. I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: Beverly Hills Hyperbaric Center (BHHC), and/or their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;
B. INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result or participation in this activity, whether caused by the negligence of release or otherwise.
C. I UNDERSTAND there are no guarantees or warranties to the effectiveness of the treatments, and that the indications for treatment may or may not be proven.

I acknowledge that BHHC and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting a specific activity on their behalf.
I acknowledge that this activity may involve a test of a person's physical and mental limits and carries with it the potential for death, serious injury, and property loss. This risks include, but are not limited to, those caused by terrain, facilities, temperature, weather, condition of participants, equipment, vehicular traffic, lack of hydration, and actions of other people including, but not limited to, participants, volunteers, monitors, and/or producers of the activity. These risks are not only inherent to participants, but are also present for volunteers.
I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity. I understand while participating in this activity, I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by the activity holders, producers, sponsors, organizers, and assigns.
The accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.
I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Participant's Signature	Participant's Name	Date
*Parent/Guardian Signature *(If under 18 years old, Parent or Guardian must also sign.)*		

CANCELLATION/TIME CONSTRAINTS POLICY

We take great pride in the TIME and SERVICE we provide to our clients. We take your time seriously and are committed to serving you with the highest level of respect, integrity and in the most cost effective manner. While some client cancellations are inevitable, cancellations with less than 24 hours notice, missed appointments (no-shows) or being late for an appointment, have unfortunately become a great expense to our organization.

We will institute the following cancellation policy:

- There will be a $100 charge for each cancellation/no-show without a 24 hour notice.
- Full payment for Hyperbaric treatment will be required upfront if 2 or more cancellations/no shows occur consecutively to be eligible for future scheduling.

Treatment packages offered provide a significant discount to a course of therapy. If at any point of time, a client requested a refund for unused treatment purchased under the discounted treatment package, a calculation will be made based on the full cost of the completed treatments provided (not at the discounted rate) and any additional amount left over will be refunded.

I have read and understood the above Policy. As an active client of Beverly Hills Hyperbaric Center, I will adhere to this policy and will be financially responsible for any fees incurred as a result of this policy.

Signature of Participant	Date	Witness

24 hour notice is required for any cancellation of scheduled appointments without exception.