OFFICE POLICY AND PROCEDURE

_____ **1.** All new patients must complete the ***Patient Health History*** form and sign the ***Notice of Privacy Practices*** as well as and the ***Patient Agreement*** form.

_____ **2.** You will have a consultation with the doctor to discuss your health issues.

_____ **3.** Preliminary screening tests will be performed to help determine if you are a candidate for our treatment. If you are not accepted as a patient, we will assist you in locating the type of physician or specialist we feel your condition requires.

_____ **4.** Additional diagnostic examinations, such as laboratory tests, neurological and orthopedic tests, kinesiological exams, x-rays, blood and urinalysis may also be required.

_____ **5.** If you should require immediate medical attention, emergency first aid will be administered and 911 will be called.

_____ **6.** The doctor will review with you all of the findings, explain their significance and make recommendations for treatment. We welcome family members to attend the **Report of Findings** at your request. Patients that respond the best are those who learn to help themselves. Our job is to help you do so.

_____ **7.** Treatments begin and continue as scheduled until your condition is fully corrected, or until the maximum possible improvement is obtained. If you do not respond to treatment, or are dissatisfied with your progress, you may stop taking treatment at any time without further financial obligation, (except for services previously rendered). In addition, upon request, your case records will be made available for review, by the physician of your choice.

_____ **8.** Payment is required at the time the above service is performed. We accept cash, checks and most major credit cards. In Pennsylvania, South Carolina and Virginia we will supply you with a super bill for you to submit to your insurance for possible reimbursement. Not all insurances cover our treatments; you are responsible for all charges. We are NOT participating providers of any insurance programs including Medicare and Medicaid. We do not accept Personal Injury or Workman's Compensation cases.

_____ **9.** We reserve time especially for you. If you are unable to keep your appointment, please let the office know at least 24 hours in advance so other patients who are waiting for appointments may utilize this time. A charge of $50.00 will be made unless the office receives the required notice.

A good relationship can only be maintained through open lines of communications. Please feel free to ask any questions and discuss any topics. We are here for YOU!

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATOIN IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any tie. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant tot the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization. Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at and get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page. $10.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost- based fee for providing your health information in this format. If you prefer, we will prepare a summary or an explanation of your health information for a

fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website, or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

By signing below I acknowledge that I have received and reviewed all the information pertaining to the Notice of Privacy Practices. The Doctor is authorized to treat me and will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Date:_____ Name: _____

PATIENT AGREEMENT

_____ I fully understand that Robert J. Kay DC, ND, CNC, Evan G. Kay DC, are not medical doctors, psychologists, acupuncturists or massage therapists. I also understand that they do not diagnose or treat for any specific disease or condition. If I have any disease, health problems or health conditions, I am now being advised to seek qualified medical advice from a licensed physician.

_____ I fully understand that Robert J. Kay DC, ND, CNC is a licensed and practicing Chiropractor in the states of Virginia, Pennsylvania and South Carolina **ONLY**. I fully understand that Evan G. Kay DC is a licensed and practicing Chiropractor in the states of Pennsylvania, Maryland, and South Carolina **ONLY**.

_____ I am here solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or for any investigative purpose.

_____ I understand Robert J. Kay DC, ND, CNC, Evan G. Kay DC, teach their patients how to build their own health through training in the effective use of life-style modification, pollution avoidance, clean air, pure water, proper foods, diet, rest, exercise, goal orientation, positive mental attitude and stress reduction techniques.

_____ I understand Robert J. Kay DC, ND, CNC, Evan G. Kay DC, use Body Energetics Technique (a muscle testing energy technique) to test and treat their patients.

_____ Recommendations, suggestions and references for meals, menus and related purchases as well as taking nutritional supplements is up to the discretion of the patient and is for building the body, increased stamina and energy and general health maintenance and **DOES NOT** involve diagnosing, prognosticating or prescribing for the treatment of any disease or health condition.

_____ I understand that Robert J. Kay DC, ND, CNC, Evan G. Kay DC, are dedicated to educating their patients to help themselves achieve better health with emphasis on education and self-care.

_____ I understand that Hyperbaric Treatment Center of MD is owned and operated by Kay Chiropractic & Natural Health Care Center, LLC

_____ I have read and understand what is written above. My signature below signifies that I agree to retain Robert J. Kay DC, ND, CNC, Evan G. Kay DC, to educate me through lecture, Body Energetics Technique, QEST4 Testing, HBOT, IonCleanse Detoxification, Beautiful Image Microcurrent Face Lift and Body Sculpting and any other methods they deem useful to help me reach my goal.

Client Signature:_____Date: _____

PATIENT HISTORY

Name: **Date:**

Address: **City:**

State: **Zip:** **Home Phone:**

Cell Phone: **Work Phone:**

Email: **Date of Birth:** **Age:**

Gender: **Marital Status:** **Referral:**

Chief Complaint:

When Did The Condition Begin:

Condition Getting: (circle)____Better____Worse___Constant____Comes and Goes___
Condition Interfering With: (circle)_____ _Work____Sleep____Daily Routine_____
Do You Smoke: NO YES What: How Much How Long: _

Check off what applies:

	GENERAL		Low Back Pain		Difficult Digestion
	Allergy		Neck Pain		Abdomen Distension
	Chills		Stiffness		Excessive Hunger
	Convulsions		Pain Between Shoulders		Gall Bladder Problem
	Dizziness		Pain in Shoulders		Hemorrhoids
	Fainting		Pain in Arms		Intestinal Worms
	Fatigue		Pain in Elbows		Jaundice
	Fever		Pain in Hands		Liver Trouble
	Headache		Pain in Hips		Nausea
	Loss of Sleep		Pain in Knees		Stomach Pain
	Loss of Weight		Pain in Feet		Poor Appetite
	Nervousness		Pain in Tail Bone		Vomiting
	Depression		Poor Posture		Vomiting Blood
	Neuralgia		Sciatica		
	Numbness		Spinal Curvature		EENT
	Sweats		Swollen Joints		Asthma
	Tremors				Colds
	Anxiety		GASTRO-INTESTINAL		Crossed Eyes
			Gas		Deafness
	MUSCLE & JOINT		Belching		Dental Decay
	Arthritis		Colitis		Earache
	Bursitis		Colon Troubles		Ear Discharge
	Foot Trouble		Constipation		Ringing in Ears

	Hernia		**Diarrhea**		**Swollen Glands**
	EENT Cont.		**Poor Circulation**		**Loss of Pigment**
	Enlarged Thyroid		**Rapid Heart Beat**		
	Eye Pain		**Slow Heart Beat**		**GENITO-URINARY**
	Failing Vision		**Ankle Swelling**		**Bed Wetting**
	Cataracts				**Blood in Urine**
	Far Sighted		**RESPIRATORY**		**Frequent Urination**
	Near Sighted		**Chest Pain**		**Loss of Bladder Control**
	Color Blind		**Chronic Cough**		**Kidney Infection**
	Gum Troubles		**Difficulty Breathing**		**Kidney Stones**
	Hay Fever		**Spitting Up Blood**		**Prostate Trouble**
	Hoarseness		**Phlegm**		**Pus in Urine**
	Nasal Obstruction		**Wheezing**		
	Nosebleeds				**WOMEN ONLY**
	Sinus Infection		**SKIN**		**Congested Breasts**
	Sore Throat		**Boils**		**Cramps**
	Tonsillitis		**Bruising**		**Excessive Flow**
			Dryness		**Hot Flashes**
	CARDIO-VASCULAR		**Hives**		**Irregular Cycle**
	Arteriosclerosis		**Allergy**		**Menopause**
	High B/P		**Itching**		**Painful Menstruation**
	Low B/P		**Rash**		**Vaginal Discharge**
	Pain Over Heart		**Varicose Veins**		**Pregnant**

Check The Following Conditions You Have Had:

	Alcoholism		**Epilepsy**		**Pleurisy**
	Anemia		**Migraine Headaches**		**Pneumonia**
	Appendicitis		**Goiter**		**Polio**
	Arteriosclerosis		**Gout**		**Rheumatic Fever**
	Arthritis		**Heart Disease**		**Scarlet Fever**
	Cancer		**Influenza**		**Stroke**
	Neck/Back Surgery		**Lumbago**		**Tuberculosis**
	Cold Sores		**Malaria**		**Typhoid Fever**
	Diabetes		**Measles**		**Ulcers**
	Diptheria		**Miscarriage**		**STD's**
	Eczema		**Multiple Sclerosis**		**Whooping Cough**
	Emphysema		**Mumps**		**Immunizations**

Please list any other medical conditions you have had (include accidents/illnesses):

_____

_____

_____

Family Health History:

_____

_____

List All Medications: _____

_____

_____

_____

List All Nutritional Supplements:

_____

_____

_____

Person Responsible For Account:

Name:_____**Relationship:**_____

Billing Address:_____

SS#:_____**Dl#:**_____**State:**_____

Work Phone:_____

Payment Method:_____**CASH**_____**CHECK**_____**CREDIT CARD**

Credit Card #:_____

Exp. Date:_____**CVV:**_____**Billing Zip Code:**_____

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the Doctor. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any and all legal fees, collection agency fees, and any other expenses incurred in collecting this debt. A $25.00 bounced check fee will be assessed for any returned checks. Any un-opened/un-expired nutrients can be returned for a credit toward your next visit or another nutrient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient Signature:_____**Date:** _____

MEDICARE OPT OUT

Dr Robert J Kay, Dr Evan G Kay and Dr Michael Batla, declare under penalty of perjury that the following is true and correct to the best of our knowledge, information, and belief:

1. We are Chiropractors licensed to practice Chiropractic in the states of (1) PA (excluding Dr Batla), (2) SC and (3) MD. Our office addresses are; (1) 600 Carlisle St. Ste B, Hanover, PA. 17331 and (2) 1051 Johnnie Dodds Blvd Ste D, Mt Pleasant SC, 29464 and (3) 7001 Johnny Cake Rd., Suite 103. Windsor Mill, MD. 21244 our telephone number is 443-745-6171. We promise that, for a period of two years beginning on the date that this affidavit is signed (the "Opt-Out Period") and continuing indefinitely with automatic extensions of the 2-year opt out period unless terminated by us as allowed by Title 1 Section 106(a)(1) Medicare Access and CHIP Reauthorization Act of 2015, We will be bound by the terms of both this affidavit and the private contracts that we enter into pursuant to this affidavit.

2. We have entered or intend to enter into a private contract with a patient who is a beneficiary of Medicare ("Medicare Beneficiary") pursuant to Section 4507 of the Balanced Budget Act of 1997 for the provision of medical services covered by Medicare Part B. Regardless of any payment arrangements We may make, this affidavit applies to all Medicare-covered items and services that We furnish to Medicare Beneficiaries during the Opt-Out period, except for emergency or urgent care services furnished to Beneficiaries with whom we had not previously privately contracted. We will not ask a Medicare Beneficiary who has not entered into a private contract and who requires emergency or urgent care services to enter into a private contract with respect to receiving such services, and We will comply with 42 C.F.R. § 405.440 for such services.

3. We hereby confirm that We will not submit, nor permit any entity acting on our behalf to submit, a claim to Medicare for any Medicare Part B item or service provided to any Medicare Beneficiary during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation for which I am required to submit a claim under Medicare on behalf of a Medicare Beneficiary, and I will provide Medicare-covered services to Medicare Beneficiaries only through private contracts that satisfy 42 C.F.R. § 405.415 for such services.

4. We hereby confirm that we will not receive any direct or indirect Medicare payment for Medicare Part B items or services that we furnish to Medicare Beneficiaries with whom we have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare Beneficiary under a Medicare+Choice plan, during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation. We acknowledge that, during the Opt-Out Period, our services are not covered under Medicare Part B and that no Medicare Part B payment may be made to any entity for my services, directly or on a capitated basis, except for items or services provided in an emergency or urgent care situation.

5. A copy of this affidavit is being filed with each local Medicare carrier, the designated agent of the Secretary of the Department of Health and Human Services, no later than 10 days after the first contract to which this affidavit applies is entered into.

Executed on _____ by Dr Robert J Kay, Dr Evan G Kay, Dr Michael Batla

_____ _____

_____

PRIVATE CONTRACT FOR MEDICARE PATIENTS

This agreement is between Dr Robert J Kay and/or Dr Evan G Kay and/or Dr Michael Batla , who has businesses at (1). 600 Carlisle St., Ste B, Hanover, PA. 17331 and (2). 1051 Johnnie Dodds Blvd., Ste D, Mt Pleasant SC, 29464 and (3) 7001 Johnny Cake Rd., Suite 103. Windsor Mill, MD. 21244 and patient _____ who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Chiropractic Physician has informed said Patient that the Chiropractic Physician has opted out of the Medicare program effective on 06/01/2015, for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following Chiropractic services to the Patient:

1. Physical Exam
2. Chiropractic Manipulation
3. Body Energetics Technique and Treatments
4. Nutritional Supplements
5. IonCleanse Detoxification
6. Asyra Testing
7. Hydro Bed Therapy
8. HBOT Therapy

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Doctors Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on (Date) _____

by [Patient] _____ and (Physician) _____

Hyperbaric Oxygen Therapy (HBOT)

The Hyperbaric Treatment Center of Maryland is owned and operated by Kay Chiropractic and Natural health Care Center LLC.

The following are answers to some common patient questions about hyperbaric oxygen (HBOT) therapy

Do I need a physician referral?

Patients must have a referral from their physician to make an appointment for HBOT treatment. Your physician will continue to be responsible for your general medical management and will closely monitor your care.

What should I expect?

During HBOT treatments, you will relax in a clear, atmosphere-controlled chamber. You will have the ability to move around, listen to music, read a book, nap or converse with the staff.

Is HBOT therapy safe?

We will work with your physician and closely monitor you during treatment to ensure your therapy is safe and effective. HBOT treatment normally has few or no side effects, which will be discussed directly with you.

Is HBOT therapy painful?

Treatment in the HBOT chamber is not painful. You may feel a plugging sensation in your ears from the pressurization, similar to what is experienced while flying in an airplane.

How many treatments will I need?

The number of treatments required depends on each patient's specific condition. Although a few conditions require only three to six treatments, most conditions require as many as 20-40 treatments. Your schedule will depend on your body's response to HBOT therapy.

Is HBOT covered by insurance?

HBOT therapy is reimbursable by most other third party payers for certain accepted conditions. In most cases, preauthorization must be obtained prior to the start of therapy.

Colds and Illnesses: Please notify us if you have symptoms of cold, flu, fever, cough, sore throat, runny nose, fever blisters, cold sores, nausea, vomiting or general body aches. These conditions may cause a temporary delay in your treatment.

Smoking: Using tobacco of any kind, including cigarettes, pipe tobacco, cigars and snuff, limits the delivery of blood and oxygen to your body tissues.

Cosmetics: Any makeup, hair spray, perfume, deodorant or shaving lotion that has a petroleum or alcohol base may not be used immediately prior to treatment. Discuss your skin products with staff to make sure they are safe to use in the HBOT therapy chamber.

Additional Information: No watches, rings or jewelry are allowed in the chamber while receiving HBOT therapy. In addition, any prosthetic devices, dentures, partial plates, hearing aids and certain types of contact lenses will need to be removed prior to treatment.

Contraindications for HBOT treatment:

1. Untreated tension pneumothorax
2. Upper respiratory infections
3. Emphysema With C02 retention
4. Asymptomatic Air cysts or blebs in the lungs
5. History of thoracic or ear surgery
6. Uncontrolled high fever
7. Pregnancy
8. Claustrophobia

What is treated with HBOT Therapy:

1. Aetna considers systemic hyperbaric oxygen therapy (HBOT) medically necessary for any of the following conditions:
    1. Acute air or gas embolism
    2. Acute carbon monoxide poisoning
    3. Acute cerebral edema
    4. Acute peripheral arterial insufficiency (i.e., compartment syndrome) requiring emergent surgical intervention (e.g., surgical or catheter directed embolectomy or bypass surgery), with imaging documentation of embolus/thrombus (e.g., MR, angiogram)
    5. Acute traumatic peripheral ischemia (including crush injuries and suturing of severed limbs) when loss of function, limb, or life is threatened and HBOT is used in combination with standard therapy
    6. Central retinal artery occlusion (CRAO), acute treatment
    7. Chemotherapy-induced hemorrhagic cystitis
    8. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management, including a six- week course of parenteral antibiotics and at least one surgical eradication/debridement attempt, unless contraindicated, with photograph (with ruler) of wound plus X-ray or bone culture documenting diagnosis. Footnotes*
    9. Compromised skin grafts and flaps , where hypoxia or decreased perfusion has compromised viability acutely (not for maintenance of split thickness skin grafts or artificial skin substitutes). Required documentation includes photograph (with ruler) of wound, type of flap, name of surgeon performing graft or flap, whether there was surgical exploration, and transcutaneous oxygen tension testing demonstrating hypoxia of flap or graft (TcPO2 less than 40 mm Hg on room air).
    10. Cyanide poisoning (with co-existing carbon monoxide poisoning)
    11. Decompression illness (“the bends”)
    12. Exceptional blood loss anemia only when there is overwhelming blood loss and transfusion is impossible because there is no suitable blood available, or religion does not permit transfusions
    13. Gas gangrene (Clostridial myositis and myonecrosis)
    14. Idiopathic sudden sensorineural hearing loss (SSHL) SSHL greater than 30 dB affecting greater than 3 consecutive frequencies of pure-tone thresholds when member has failed oral and intra-tympanic steroids, and HBOT is initiated within 3 months after onset
    15. Non-healing infected deep ulcerations (reaching tendons or bone) (Wagner grade 3 or more-- see appendix) of the lower extremity, with photographic (with ruler) documentation, in diabetic adults unresponsive to at least 1 month of meticulous wound care. Standard wound care in persons with diabetic wound includes
        1. Assessment of vascular status and correction of any vascular problems in the affected limb if possible,
        2. Optimization of nutritional status,
        3. Optimization of glucose control,
        4. Debridement by any means to remove devitalized tissue,
        5. Maintenance of clean, moist bed of granulation tissue with appropriated moist dressings,
        6. Appropriate off-loading, and
        7. Necessary treatment to resolve any infection that might be present.
        8. Assessment of vascular status and correction of any vascular problems in the affected limb if possible,
        9. Optimization of nutritional status,
        10. Optimization of glucose control,
        11. Debridement by any means to remove devitalized tissue,
        12. Maintenance of clean, moist bed of granulation tissue with appropriated moist dressings,
        13. Appropriate off-loading, and
        14. Necessary treatment to resolve any infection that might be present.

        Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during the administration of HBOT. Continued treatment with HBOT is not considered medically necessary if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Footnotes* Note: HBOT is not considered medically necessary for superficial lesions.
    16. Pneumatosis cystoides intestinalis
    17. Progressive necrotizing soft tissue infections, including mixed aerobic and anaerobic infections (Meleney's ulcer, necrotizing fasciitis), with history of inpatient treatment including antibiotics and surgical

debridement, unless contraindicated, and (where appropriate) full thickness or split thickness skin grafts, and with photographic documentation (with ruler) of the wound. Footnotes*

18. Prophylactic pre- and post-treatment for members undergoing dental surgery of a radiated jaw, where the extraction site is anticipated to be whithin the XRT portal, and where HBOT is delivered according to established (Marx) protocol, with 20 HBOT treatments prior to surgery and 10 HBOT treatments immediately after surgery
19. Radiation-induced hemorrhagic cystitis
20. Radiation necrosis (including brain radionecrosis, myoradionecrosis, osteoradionecrosis, and other soft tissue radiation necrosis) (typically up to 40 HBOT treatments considered medically necessary, plus an additional 10 treatments to support tissues after surgical reconstruction (if performed))
21. Radiation proctitis

2. Aetna considers the use of systemic HBOT experimental and investigational for the following conditions (not an all inclusive list) because there is insufficient evidence in the medical literature establishing that systemic HBOT is more effective than conventional therapies:
    1. Actinic skin damage
    2. Actinomycosis and other mycoses
    3. Acute coronary syndrome
    4. Acute or chronic cerebrovascular insufficiency/accident (including thrombotic or embolic stroke)
    5. Acute renal arterial insufficiency
    6. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation (e.g., carbon tetrachloride, hydrogen sulfide) with pulmonary insufficiency
    7. Aerobic septicemia and systemic aerobic infection
    8. Alzheimer's disease
    9. Anaerobic septicemia and infection other than clostridial
    10. Anoxic brain injury
    11. Anti-phospholipid antibody syndrome
    12. Arthritic diseases
    13. Arthritis
    14. Aseptic necrosis of the femoral head and neck
    15. Asthma
    16. Autism spectrum disorders
    17. Bacterial keratitis
    18. Bell's palsy
    19. Bone grafts or fracture healing (e.g., nonunion fractures)
    20. Brain tumors
    21. Calciphylaxis (calcific uremic arteriolopathy)
    22. Cancer
    23. Cardiogenic shock
    24. Central airway stenosis following lung transplantation
    25. Cerebral palsy
    26. Chronic bowel dysfunction after pelvic radiotherapy
    27. Chronic pain (e.g., cluster headaches, complex regional pain syndrome/reflex sympathetic dystrophy, fibromyalgia, migraines, myofascial pain syndrome, and trigeminal neuralgia)
    28. Chronic peripheral vascular insufficiency
    29. Closed head and/or spinal cord injury
    30. Cognitive impairment (e.g., senility, senile dementia)
    31. Cystic acne
    32. Depression
    33. Diabetic foot ulcers that are not infected
    34. Diabetic superficial wounds
    35. Facial neuritis
    36. Fat necrosis
    37. Frostbite
    38. Glioblastoma
    39. Heart disease
    40. Hepatic artery thrombosis
    41. Hepatic necrosis
    42. Hepatitis

43. HIV infection
44. Infective polyneuritis
45. Inflammatory bowel disease (Crohn’s disease and ulcerative colitis)
46. Intestinal anastomosis
47. Interstitial cystitis
48. Intra-abdominal abscess, pseudomembranous colitis (antibiotic-induced colitis)
49. Intra-cerebral hemorrhage
50. Intra-cranial abscesses
51. Ischemia due to lupus vasculitis
52. Legg-Calve Perthes disease
53. Lepromatous leprosy
54. Lupus vasculitis
55. Lyme disease
56. Lymphedema
57. Male infertility
58. Melasma
59. Meningitis
60. Methicillin-resistant Staphylococcus aureus (MRSA) infections
61. Multiple sclerosis
62. Myocardial infarction
63. Necrotizing arachnidism
64. Non-compromised skin grafts and flaps
65. Non-diabetic cutaneous, decubitus, pressure and venous stasis ulcers
66. Non-vascular causes of chronic brain syndrome (e.g., Alzheimer's disease, Korsakoff's disease, Pick's disease)
67. Ophthalmologic diseases (including central retinal artery occlusion, central retinal vein occlusion, diabetic retinopathy, glaucoma, keratoendotheliosis, radiation injury to the optic nerve, retinal detachment)
68. Organ transplantation and storage
69. Osteonecrosis of the jaw
70. Osteoporosis
71. Otitis externa
72. Parkinson's disease
73. Post-concussive syndrome
74. Post-operative nipple ischemia following mastectomy
75. Post-organ transplantation re-vascularization
76. Post-radiation therapy breast pain
77. Post-traumatic stress disorder
78. Pre-operative HBOT for jaw osteomyelitis
79. Prevention of radiation-induced complications of the head and neck cancers
80. Pulmonary emphysema
81. Pyoderma gangrenosum
82. Radiation-induced cholangitis, myelitis, enteritis, sarcoma
83. Radiation-induced pulmonary fibrosis/injury
84. Radiation-induced skin necrosis
85. Raynaud’s syndrome
86. Recto-vaginal fistula
87. Scleroderma (systemic sclerosis)
88. Seizure disorders
89. Sickle cell anemia
90. Sickle cell crisis or hematuria
91. Skin burns (thermal)
92. Spinal dural arterio-venous fistula
93. Superficial and/or non-infected diabetic ulcers
94. Surgical wound dehiscence
95. Systemic inflammatory response syndrome
96. Tetanus
97. Tinnitus
98. Traumatic brain injury
99. Vesicocutaneous fistula

100. Xerostomia/salivary gland dysfunction

3. Aetna considers systemic HBOT experimental and investigational for members with any of the following contraindications to systemic HBOT, as the safety of systemic HBOT for persons with these contraindications to HBOT has not been established:
    1. Concurrent administration of doxorubicin, cisplatin, or disulfiram
    2. Premature infants (birth prior to 37 weeks gestation)
    3. Untreated pneumothorax

4. Aetna considers topical HBOT directly administered to the open wound, and limb-specific hyperbaric oxygen pressurization in small limb-encasing devices experimental and investigational because its efficacy has not been established through well-controlled clinical trials.

Consent For Treatment With Hyperbaric Therapy

I have read the information pertaining to HBOT Therapy and am aware of the contraindications. By signing I agree to the use and services rendered.

Patient: _____Dr: _____
Date: _____