OFFICE POLICY

As a condition of your treatment by Optimal Health & Wellness, payment arrangements must be made in advance. Payment is expected for services rendered at the time of the first visit. Financial arrangements for subsequent treatment will be made following the diagnosis. We accept Cash, major debit or credit cards, Checks.

Patients who carry insurance understand that all services furnished are charged to your insurance as a courtesy, but that he / she is ultimately responsible for payment of all services. Patients are advised to know their policy and to acquire an insurance booklet to know what their benefits are, as we verify your benefits only once as a courtesy. If your insurance does not remit payment within 60 days, the balance will be due and payable by you.

If your indication is covered by insurance, we will prepare any necessary reports and or forms to assist you in making your collection. I understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. Further, I understand that I may come to a formalized agreement between the management of the department and myself *prior* to initiating *any* treatment; should I be declined by my provider.

All others are on a fee-for-service basis. All co-payments and deductibles are due at the time of service.

PLEASE NOTE OUR CANCELLATION POLICY: Our patients are very important to us. Missed appointments are costly and take away valuable appointment time from others. Therefore, we ask that you be aware of your commitment.

Patients must notify the office at least 48 business hours in advance in order to cancel or change an appointment. Failure to do so will result in you being charged the full cost of the appointment, which will be billed to your credit card on file. There will be no exceptions.

It is the patient's primary responsibility to maintain his or her calendar and keep the appointment. The office may offer a courtesy reminder call to you a few days in advance of the appointment; Failure to receive this courtesy call in no way releases you from the obligation to keep the appointment as scheduled.

For Your Convenience A Storage Unit Is Provided For Your Personal Items. Optimal Health & Wellness Is Not Responsible For Lost Or Misplaced Items.

Our goal is to offer services to the maximum number of patients needing care. When time is lost without regard for others, we cannot achieve this goal.

I have read, understood and agreed to the provisions of this office policy.

By _____ _____ _____

Patient's or Patient Representative's Signature | Patient's Printed Name | Date

Optimal Health & Wellness
670 Monterey Pass Road, Suite 100. Monterey Park, CA 91754 – Phone 626-551-5155 – Fax 626-551-5156
opthealthwellness@gmail.com

ARBITRATION AGREEMENT

Article 1 It is understood that any dispute or claim against Optimal Health & Wellness and/or the "Clinic" as defined herein whether for malpractice of any kind, and any other claims of any nature whatsoever including, but not limited to, any type of tort or contract, that were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, action or inaction, failure to act, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2 a) The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

"Clinic" includes Optimal Health & Wellness, all doctors, their professional corporation or partnership, all independent contractors who practice or provide service for Optimal Health & Wellness, all employees, representatives, agents, directors, officers and assignees of Optimal Health & Wellness, and any employees agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities.

b) Actions Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Clinic and Patient will be subject to compulsory binding arbitration.

c) Other Doctors, Medical Professionals, Service Providers, or Care Professionals. Patient understands that he or she may at times receive treatment from one or more Doctors. Medical Professional, Service Providers, or other type of Care Professional who are independent contractors practicing or providing services at the same facility at Optimal Health & Wellness. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such providers providing any type of service at the same facility and/or Optimal Health & Wellness will be subject to compulsory, binding arbitration.

d) Right of Action Waived. Patient understands that a claim shall be waived and forever barred if(1) on the date notice thereof is received, the claim, if asserted in a civil action would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein.

Article 3 a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the care rendered by Optimal Health & Wellness and/or Clinic to Patient, Patient will promptly notify Optimal Health & Wellness and/or Clinic so that Optimal Health & Wellness and/or Clinic may have the opportunity to resolve the matter.

b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement, Patient shall notify Optimal Health & Wellness and the Clinic in writing of his or her desire to arbitrate and shall designate an arbitrator. Within receipt of such notice, Optimal Health & Wellness and/or Clinic will designate an arbitrator to act on the parties' behalf in the event Patient actually files a claim for arbitration and pays the applicable required arbitration fees.

c) Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P 1280-1295). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d) Interpretation of Agreement. Any controversy concerning the interpretation or application of the Agreement itself shall also be submitted to arbitration in the manner provided above.

Article 4 Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give the Clinic written notice within 30 days from signing that you want to withdraw from the Agreement. However, Clinic and Patient agree that any claim arising from services rendered prior to revocation shall be subject to arbitration.

Article 5: Retroactive Effect: Also, by executing the agreement Patient agrees that this agreement covers ALL services rendered as defined in Article 1 before the date this agreement is signed whatever date the service was rendered.

Article 6: Invalid Provisions. If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ACTION OR REQUEST FOR DAMAGES DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below I acknowledge that I have received a copy.

By _____ _____ _____

Patient's or Patient Representative's Signature | Patient's Printed Name | Date

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PATIENT PERSONAL AND MEDICAL QUESTIONNAIRE

Patient Name:_____

1. Have you ever had Hyperbaric Oxygen therapy? _____When_____Why_____
2. Are you pregnant or expecting?_____
3. Do you suffer from? If yes, Please explain:
   a. Mechanical Damage of the ears or sinuses:_____
   b. Chronic or current ear, nose, or throat infection:_____
   c. Respiratory or lung problems:_____
4. Do you have or have you had any of the following?

	Yes	No		Yes	No
Asthma			Stroke		
Pneumothorax			Heart Attack		
Angina			Prosthesis		
Hypertension			Colostomy		
Lieostomy			Emphysema		
Diabetes			Seizures		
Pacemaker			Other: (describe)		

5. Do you take any of the following drugs?

	Yes	No
Doxorubicin		
Cisplatin		
Andriamycin		
Disulfiram		
Antabuse		
Sulfamylon		
Mafenide		
Acetate		
Other (describe)		

I certify that all the answers and information provided by me above are accurate and correct.

By _____ _____ _____

Patient's or Patient Representative's Signature | Patient's Printed Name | Date

ALL THE INFORMATION PROVIDED HEREIN IS KEPT CONFIDENTIAL

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BEFORE AND AFTER YOUR HYPERBARIC TREATMENT

If you are receiving hyperbaric treatments, it is important to understand how to clear your ears. While inside the chamber, you must help your ears to clear by equalizing the pressure you feel.

You Can Accomplish This In Four Manners:

- Yawn And Swallow
- Valsalva (Pinch Your Nose Shut & Attempt To Gently Blow Through The Nose)
- Wiggle Your Jaw Repeatedly (Up & Down, Left To Right, Or In A Circular Motion)
- If You Will Be Utilizing A "Sit Up" Chamber You Are Welcome To Chew Gum.

All of these techniques must be repeated every time you feel pressure building in your ears. If your ear does not clear using these techniques you must knock on the chamber, so we can stop for a moment and let your ears adjust to the pressure. If you do not, you may develop discomfort or pain for several days. Hyperbaric treatments should be painless.

Your ears may do some funny things while you are undergoing treatments in the hyperbaric chamber. You may experience:

- Popping Your Crackling Of The Ears (Especially During A Yawn)

You may experience some of these symptoms at any point during or following your treatment. It is important to understand that it is ok if you experience some or all of these symptoms.

- A Fullness Feeling In The Ear(S)
- May Feel As Though You Have Water In Your Ear(S)
- One Or Both Of Your Ears May Be Plugged
- Inside Your Ear May Feel Tender

Please work with us. Help us to ensure that you have a comfortable experience in the chamber and at our department. It is our privilege to be of service to you, your friends and family. Rest assured we will do all that we can in helping you receive the most therapeutic value out of your hyperbaric oxygen therapy experience.

- If You Have Nasal Congestion, Sinus Problems Or A Head Cold, On The Day Of Your Treatment, It Is Not Recommended You Receive Hyperbaric Oxygen Therapy That Day.

- Heavy Cardiovascular Exercise Is Not Recommended One Hour Prior To Your Treatments As Well As Four Hours After Your Treatment.

- 100% Cotton Clothing Is Required For H.B.O.T.

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- Electronic Devices, All Metal, Jewelry And Watches, AreNotPermittedInsideTheHyperbaric Chamber.
- No Makeup, Perfumes Or Skin Lotion.
- Please Empty All Pockets Before Treatment.
- Please Wear Socks.
- If You Have Had Any New Dental Work Especially Fillings, You Must Wait 48 Hours Before Going In The Chamber To Preserve The Integrity Of The Fillings.
- If You Have, Any Questions Regarding Your Medications Consult The Hyperbaric Technician.
- Do Not Smoke At Least Four Hours Prior to Your Treatment.
- **Do Not Fly Or Drive To A Higher Altitude** Within Twelve Hours After Completing A Treatment.

I have read, understand and agree to the requirements of both pre and post Hyperbaric treatment conduct as the patient.

By _____ _____ _____

Patient's or Patient Representative's Signature | Patient's Printed Name | Date

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INFORMED CONSENT FOR HYPERBARIC OXYGEN TREATMENT

I hereby authorize the Optimal Health & Wellness to treat me in the hyperbaric chamber and do all that is required as part of that therapy.

If any unforeseen conditions arise during the course of this treatment, I do herby authorize and request the physician and his / her assistants to perform such additional procedures and / or to render such treatment as he may in his / her professional judgment deem necessary.

The physician or a staff member had explained to me the general methods of the procedure and explained to me the special risks, contraindications, and consequences associated with hyperbaric oxygen therapy. These include, but are not limited to:

- Barotruama
- Pulmonary Over Pressure Syndrome
- Oxygen Toxicity
- Changes To My Visual Acuity
- Claustrophobia
- Fire

The alternatives to this therapy have been explained and I have been informed that I can refuse treatment. I understand and acknowledge that no guarantee or assurance has been made to me regarding the results or risks, and I assume such risk as explained to me. I also consent to and authorize The Administration of Medication to me during the administration of H.B.O.T., and I assume all risks in connection with use of such treatment.

I certify that I have read, or have been read to me this consent and fully understand its contents, and hereby consent and agree to the terms

By _____ _____ _____

Patient's or Patient Representative's Signature | Patient's Printed Name | Date

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