

## Patient Information

**Patient's name:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

Parent's or Guardian's name, if applicable: \_\_\_\_\_

**Patient's address:** *Street* \_\_\_\_\_  
*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip code* \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Contact phone #:** ( ) \_\_\_\_\_ **← Yes, it is ok to leave messages at this phone #** **2nd phone #:** ( ) \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **REQUIRED** **Marital Status:** [ ] Married [ ] Not Married [ ] Widowed

**Emergency contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
*Please provide a phone # different than the above #s*

**Emergency phone:** ( ) \_\_\_\_\_ **Spouse's name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **2<sup>nd</sup> Physician Name:** \_\_\_\_\_

**Physician Phone:** ( ) \_\_\_\_\_ **2<sup>nd</sup> Physician Phone:** ( ) \_\_\_\_\_

**Physician Address:** \_\_\_\_\_ **2<sup>nd</sup> Physician Address:** \_\_\_\_\_

**What is the medical reason you are here for treatment?** \_\_\_\_\_

**Are you pregnant?** Yes or No You should not be treated if you are pregnant or become pregnant.

**Are you contagious?** Yes or No Explain: \_\_\_\_\_

**Do you have back problems?** Yes or No Explain: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Current Medications:** *See the reverse side of this form for additional space for Medication list* \_\_\_\_\_

I certify that the above Patient Information is true and accurate. I will advise Bay Area Hyperbarics if there is any change in Patient Information, Medical Problems, Allergies, Medications, Medical History, Insurance Information or any other pertinent item or condition related to my (or my child's, or my ward's) Hyperbaric Oxygen Therapy. I further authorize the release of any medical or other information necessary for claim processing or on the request of physicians or providers involved in my care.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient Information (*con't*)

**Patient's name:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

**Current Medications**

*(continued from front page):*

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Your height: \_\_\_\_\_ *Ft* \_\_\_\_\_ *In*

Your weight: \_\_\_\_\_ *lbs*

Hospital Preference, if any: \_\_\_\_\_

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I further authorize the release of any medical or other information necessary for claim processing or on the request of physicians or providers involved in my care.

*Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

## Patient Medical History and Medications

**Patient's name:** \_\_\_\_\_ *Office Use Only*

Diagnosis or medical condition: \_\_\_\_\_ Diagnosis Code(s): \_\_\_\_\_

### Medical History

Are you currently undergoing radiation therapy or will you soon be? **Yes, dates of radiation** \_\_\_\_\_ **or No**

Have you had or do you currently have any of the following? Please circle Yes or No for each item.

Diabetes	Yes	No	Cataracts	Yes	No
Epilepsy or Seizure Disorder	Yes	No	Optic Neuritis	Yes	No
Heart Failure	Yes	No	Fever – currently	Yes	No
COPD/Lung Disease, any type	Yes	No	Sleep Apnea? Wear Night Mask?	Yes	No
Asthma or Emphysema	Yes	No	Congenital Spherocytosis	Yes	No
Pneumothorax/Collapsed Lung	Yes	No	Dental Disease	Yes	No
Thoracic Surgery	Yes	No	Claustrophobia/Panic Attacks	Yes	No
Pulmonary Cysts, Abscesses	Yes	No	Viral Infection – currently	Yes	No
Cancer/Malignant Tumor	Yes	No	Upper Respiratory Infection	Yes	No
High Blood Pressure	Yes	No	Sinusitis	Yes	No
Could you be pregnant?	Yes	No	Heart Disease/Heart Problems	Yes	No
HIV positive? AIDS?	Yes	No	MRSA? (Staphylococcus)	Yes	No
Are you pregnant or intend to become pregnant?	Yes	No			

### Surgeries

Type of surgery(s) and date(s): \_\_\_\_\_

**Medications:** Are you taking any of the following? **Please circle Yes or No for each item.**

Alcohol	Yes	No	Doxorubicin (Adriamycin)	Yes	No
Nicotine/Do you smoke?	Yes	No	Amphetamines	Yes	No
Acetazolamide	Yes	No	Bleomycin	Yes	No
Vitamin C (over 1,000 mgs daily)	Yes	No	Disulfram (Antabuse)	Yes	No
Digitalis	Yes	No	Epinephrine	Yes	No
Lidocaine	Yes	No	Narcotics	Yes	No
Nitroprusside	Yes	No	Phenothiazines	Yes	No
Steroids	Yes	No	Sulfamylon	Yes	No
Thyroid Hormone	Yes	No	CIS-Platinum	Yes	No
Insulin	Yes	No	Intrathecal Pump	Yes	No
Chemotherapy drugs	Yes	No	Other?		
Taxotere (Docetaxel, Taxol)	Yes	No			

If at any time during the period of my hyperbaric oxygen therapy treatment, my medications change, or there is a change in my medical condition (including a fever or cold), I will notify the Bay Area Hyperbarics staff immediately.

*Patient's Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Complete at or around 20 visits: There has been no change in my medications or medical condition that is pertinent to my treatment at Bay Area Hyperbarics. (Please note any change above, if applicable.)*

*Patient's Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_



# Insurance Information

**Patient's name:** \_\_\_\_\_ Social Security #: \_\_\_\_\_  
*REQUIRED*

*Required* - COPY OF INSURANCE CARD, DRIVER'S LICENSE AND MEDICARE CARD (if applicable)

**I have the following plan:**

- Insurance plan (patient pays deductible and coinsurance according to plan benefits)
- Self pay (patient has no insurance *or* his/her insurance is not expected to pay for the hyperbaric treatment)
- Medicare alone *or* Medicare with Secondary Insurance (Bay Area Hyperbarics is *not* a Medicare provider)
- Other – explain: \_\_\_\_\_

**Primary Insurance (other than Medicare)**

Is this insurance through <input type="checkbox"/> YOUR Employer? OR <input type="checkbox"/> your SPOUSE'S Employer?	Name of Employer: _____
Primary Insurance Company: _____	Type of Insurance POS, PPO, HMO, etc.: _____
Insurance Company's Phone number: (    ) _____	Subscriber Date of Birth: _____
Group or Policy Number: _____	Insurance ID or Social Security #: _____
Subscriber Name, if different than Patient: _____	
Patient's Relationship to Subscriber: _____	Is your condition or injury related to: <input type="checkbox"/> Employment? <input type="checkbox"/> Auto Accident? <input type="checkbox"/> Other Accident?

**Supplemental or Secondary Insurance, if applicable**

Is this insurance through <input type="checkbox"/> YOUR Employer? OR <input type="checkbox"/> your SPOUSE'S Employer?	Name of Employer: _____
Supp or Secondary Insurance Company: _____	Type of Insurance POS, PPO, HMO, etc.: _____
Group or Policy Number: _____	Insurance ID or Social Security #: _____
Subscriber Name, if different than Patient: _____	Subscriber Date of Birth: _____
Patient's Relationship to Subscriber: _____	

I authorize payment of medical benefits to the provider of Hyperbaric Oxygen Therapy treatments, Bay Area Hyperbarics. I further authorize the release of any medical or other information necessary for claim processing or on the request of physicians or providers involved in my care.

For my convenience, Bay Area Hyperbarics will bill my insurance directly. I will promptly sign over to Bay Area Hyperbarics any checks or payment received from insurance and/or Medicare for my Hyperbaric Oxygen Therapy. I understand that I am ultimately responsible for the payment of all my hyperbaric treatment sessions.

*Patient's Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_



## Patient Payment Agreement

**Patient's name:** \_\_\_\_\_

*Payment is expected at the time of service. We will work with you and your insurance company to facilitate the payment process; however you are ultimately responsible for the cost of your Hyperbaric Oxygen Therapy.*

As of the date of this agreement and based on the insurance and financial information I provided to Bay Area Hyperbarics, the following is my payment obligation to Bay Area Hyperbarics. These amounts are subject to change if: (1) my insurance plan, deductible and/or coinsurance changes, (2) further clarification of my insurance coverage is necessary, or (3) my treatment plan is extended or modified.

**My cost per treatment is:** \$ \_\_\_\_\_ Insurance reimbursement, if any, has already been taken into consideration.  
Please initial \_\_\_\_\_

**Because the cost per treatment may be different for other patients based on a number of factors, I agree to keep my payment arrangement confidential and not disclose my treatment cost to patients, other persons or facilities.**

Payment arrangement - I agree to pay for my hyperbaric oxygen therapy in the following way:

- Amount: \$ \_\_\_\_\_ One-time payment, or
- Amount: \$ \_\_\_\_\_ Daily (at time of treatment) payment, or
- Amount: \$ \_\_\_\_\_ Weekly payment, or
- Amount: \$ \_\_\_\_\_ Monthly payment, or
- Amount \$ \_\_\_\_\_ Other (explain): \_\_\_\_\_

If I pre-pay 20 treatments, I may qualify for a 10% discount on those 20 treatments. (Patients on financial accommodation or a scholarship are excluded from this discount.)

**I authorize Bay Area Hyperbarics to charge my credit card to make payment(s):** VISA or MasterCard

Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Exact Name on Credit Card: \_\_\_\_\_

Billing Address for Credit Card: \_\_\_\_\_

Note: If you are on a payment arrangement contract, you agree that this credit card number will be kept on file by Bay Area Hyperbarics to be charged pursuant to this signed Patient Payment Agreement, until your balance is paid in full.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



## Policies and Procedures Agreement

- Insurance Policy:** As a courtesy to me, Bay Area Hyperbarics will bill my insurance. If for any reason my insurance does not cover the treatments, I agree to pay the negotiated amount to BAH.
- Insurance Payment:** If my treatments are covered by insurance, I understand that I am responsible for any deductibles, co-payments, and applicable co-insurance which are due prior to each treatment, unless other arrangements are made.
- Patient Payment:** If I am paying for the cost of my treatments myself, or my insurance does not cover the cost of my treatments, I understand that a payment per treatment will be assessed to me and is due and payable at the time of the treatment, unless prior arrangements are made.
- Past Due Policy:** Accounts over 90 days past due will be assigned to a collections agency. I agree to be responsible for payment of any and all costs associated with collecting past due amounts and any attorney's fees. I agree to pay 1.5% interest per month (18% annum) for any amounts due over 60 days.
- Returned Checks:** All returned checks will be subject to a \$25 per check return item fee, payable within 15 days.
- Cancellation and Tardiness:** I understand that I must call Bay Area Hyperbarics at least 24 hours in advance to cancel or to reschedule a treatment or I will be subject to a fee of \$35 for each missed treatment. In addition, I understand that if I am late for a scheduled appointment, my treatment time may be reduced accordingly and that I am still liable for payment of a full treatment.
- Children and Family:** I understand that no children under the age of 14 years old are allowed unattended in the treatment area. I also understand that myself as well as other family members or friends are prohibited to be around any chamber or by the controls of any chamber unless authorized and in the presence of a technician.
- Physician's Approval:** I have received the approval of my physician to receive Hyperbaric Oxygen Therapy. I have a written prescription for this treatment from my physician.
- Loss of Valuables:** I understand that Bay Area Hyperbarics or any of its staff members is not held responsible for the loss of any personal belongings.
- Hold Harmless Agreement:** I agree to hold harmless Bay Area Hyperbarics for any results the Hyperbaric Oxygen Therapy treatments may have. I understand the possible side effects and risks of Hyperbaric Oxygen Therapy.

Print name: \_\_\_\_\_

Patient's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Possible Side-Effects of Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy (HBO) is a painless non invasive process. You should feel comfortable at all times during your treatment. If you do not, speak to the technician immediately. Ear pain should be addressed immediately during treatment.

**Ears:** One of the most likely side-effects, if any, that you might feel during your hyperbaric treatments is the pressure changes which may affect your eardrum. Your technician will teach you the valsalva maneuver which is a technique that allows you to equalize the pressure in the middle ear. We will also give you water to sip which can ease ear pressure should you have any. If you do have difficulty with pressure on your ears, a nasal decongestant may help. Discuss any problems or concerns you may have with the technician.

**Sinus:** Sinus Squeeze is very rare but is caused by changes in pressure. Pain may be felt around the sinus areas of the face. This usually occurs if the sinuses are blocked by mucus or tissue. Always inform the technician if you feel uncomfortable or feel any pain.

**Other Side-Effects:** Some mild physiological changes and symptoms may present themselves over the course of your treatments; some may be due to medication interactions. It is important that you advise your technician if any of the following symptoms arise:

- Nausea.
- Changes in vision – temporary changes in eyeglass prescription may occur. These changes may be permanent in only about 2% of those patients; usually the change is for the better.
- Numbness or tingling in the fingers or facial twitching.
- Shortness of breath or dizziness.
- Restlessness and/or irritability.
- Tinnitus (ringing of the ears).
- Out of the ordinary physical or mental changes.
- Hyperbaric Fatigue Syndrome - fatigue that occurs after treatments.
- Herxheimer Reaction - for patients with infections, fatigue or an enhancement of symptoms may occur as a reaction to the large amount of bacteria being destroyed.
- Oxygen Toxicity - in rare situations (1 in 10,000), oxygen toxicity can produce a seizure. The seizure has no lasting effect.

Call us as soon as possible if any of the above or the following occurs during your course of treatment: colds, flu, upper respiratory infection, sinusitis, high fever, viral infection, vomiting, headache, or any other out-of-the-ordinary symptoms or concerns.

We are here to help you get better. Please let us know if there is anything we can do that would ensure your time with us is comfortable and pleasant. If you have any concerns and/or develop problems with your health, call your physician immediately.

Patient's signature: \_\_\_\_\_

Date: \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES (FACILITY COPY)

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

**Summary:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	January 1, 2009
Contact Person	Lisa St. John
Phone Number	408-356-7438

**Acknowledgement of Notice of Privacy Practices**

“I hereby acknowledge that I have received a copy of this clinic’s **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the clinic will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.”

\_\_\_\_\_  
Patient or Representative’s Name (please print)

\_\_\_\_\_  
Patient or Representative’s Signature

Patient refused to sign     Patient was unable to sign because

\_\_\_\_\_



# NOTICE OF PRIVACY PRACTICES (PATIENT COPY)

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

**Summary:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

- 7. The right to inspect and copy your information;
- 8. The right to request corrections to your information;
- 9. The right to request that your information be restricted;
- 10. The right to request confidential communications;
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- 12. The right to paper copy of the Notice.

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\_\_\_\_\_  
Patient or Representative’s Name (please print)

\_\_\_\_\_  
Patient or Representative’s Signature

Patient refused to sign     Patient was unable to sign because

\_\_\_\_\_

## Preparing for Your Hyperbaric Oxygen Therapy Treatment

One of our main objectives is to inform you of what to expect during your hyperbaric treatments with us. Prior to your first treatment session you will be asked to come in a half hour early to go through an orientation. The purpose of this orientation is to answer any questions you may have and to review how your daily routine will go. If you have received our medical intake forms please fill them out ahead of time and bring them with you. Please feel free to ask any questions, we are here to help you.

- Personal Items:** For your safety and the safety of those around the chambers, NOTHING can be taken into the chamber with you. Each chamber is accommodated with a mattress, pillows, blankets and water. No jewelry, metals, pens, pencils or papers are allowed. This includes books.
- Clothing:** You will be provided with 100% cotton clothing to change into for your hyperbaric treatments. We ask that these clothes remain in your assigned drawer so you can wear them day-to-day. You can wear your own clothing provided the material is 100% cotton and it contains no metal in the form of snaps, zippers, etc.
- Cosmetics:** Please do not wear any make-up, hairspray, gels, lotions, colognes, perfumes, wigs or hairpieces during your hyperbaric treatments.
- Food and Drinks:** It is strongly recommended that you eat one hour prior to your treatment. If you forget or cannot arrange this, let your technician know; he/she can provide you with a snack. To obtain full benefit from your treatments, it is recommended that you avoid food and beverages that contain caffeine. Consumptions of coffee, tea and caffeinated drinks should be kept to a minimum during the time you are receiving treatment as caffeine constricts blood vessels. Also, alcoholic beverages should be avoided before your treatments because of alcohol's diuretic effect. If you are taking Vitamin C, do not take more than 1,000 mg daily.
- Smoking (nicotine):** Nicotine greatly compromises the effectiveness of your treatments. It constricts blood vessels which decreases blood flow to tissue areas, thus slowing down the healing process. Every attempt should be made to quit or temporarily stop smoking. If you must smoke please do so as long before your treatment and as late after your treatment as possible.
- Video and Music:** Many patients chose to watch DVDs or listen to music during their treatments. Although we have a wide variety of movies, tapes and CDs, you are welcome to bring your own.
- Scheduling:** Every attempt will be made to plan your treatments so that they fit your schedule. Once your time slot is established, we try to keep it reserved for you for the duration of your treatments. In the event you begin to miss appointments, you are unable to come in, or we have an emergency patient, we may need to assign your time slot to another patient. Keep in mind that generally, time slots are on a first come first serve basis. As patients complete their treatment plan a more desirable time slot may open up, in which case we can offer it to you. **Please arrive 15 minutes prior to your scheduled treatment time in order to change.** Our daily treatment schedule runs smoothly if patients arrive on time. If you are late your treatment time may have to be shortened. A \$35 fee may apply if you cancel your appointment less than 24 hours in advance or if you are a "no show" for your appointment.

## Patient Symptom Questionnaire

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Diagnosis or health issue:** \_\_\_\_\_

**Number of completed hyperbaric treatments @ today's date:** \_\_\_\_\_

	<i>No Problem</i>		<i>Serious Problem</i>	
<b>Mobility</b>	1	2	3	4
Ability to walk	1	2	3	4
Upper body movement	1	2	3	4
<b>Cognitive</b>	1	2	3	4
Memory	1	2	3	4
Speech	1	2	3	4
Brain "fog"	1	2	3	4
Headaches	1	2	3	4
<b>Pain</b>	1	2	3	4
Legs/Feet	1	2	3	4
Arms/Hands	1	2	3	4
Torso/Stomach/Chest	1	2	3	4
Head/Mouth/Face	1	2	3	4
Back	1	2	3	5
Other: _____	1	2	3	4
<b>Weakness in hands/arms</b>	1	2	3	4
<b>Weakness in legs/feet</b>	1	2	3	4
<b>Urination - frequency</b>	1	2	3	4
<b>Fatigue</b>	1	2	3	4
<b>Sleep</b>	1	2	3	4
<b>Eyesight</b>	1	2	3	4
<b>Other:</b>	1	2	3	4

	<i>Excellent</i>			<i>Very Poor</i>
<b>Describe your overall feeling of well being</b>	1	2	3	4
<b>Describe our overall service to you</b>	1	2	3	4

***We appreciate your comments (please use reverse side, if necessary):***



## Patient or Caregiver Testimonial (optional)

*Bay Area Hyperbarics would like to use all or part of your hyperbaric experience to help inform others. With your permission, we would like to include your testimony on our website and/or in our brochure. We will not use your last name or any other identifying information about you. Thank you so much for your testimonial!*

Please provide a brief summary of your story. What were the circumstances and condition that brought the patient to Bay Area Hyperbarics for Hyperbaric Oxygen Therapy?


Please provide a brief summary about your or the patient's success with hyperbarics. (For example: How did you feel before hyperbarics compared to after? What was the experience like? What improved about the condition? How much did the condition improve compared to before hyperbarics? What made the hyperbaric experience worthwhile, comfortable, or tolerable?)


*(Please use the back side of this paper if you need more room to write.)*

Bay Area Hyperbarics may use my above testimony in its brochure and/or on its website. I understand that Bay Area Hyperbarics will use only my first name, age, and diagnosis with the testimony, if posted.

Please use my testimonial on the website and/or brochure but do not use my first name, age, or diagnosis.

\_\_\_\_\_  
Print full name

\_\_\_\_\_  
*Relationship to patient (if applicable)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## DRIVING DIRECTIONS TO LOS GATOS

For your convenience, we have 2 clinics to serve you in the San Francisco Bay Area:

### **LOS GATOS CLINIC**

14589 S Bascom Avenue  
Los Gatos, CA 95032  
408-356-7438 phone  
408-356-7491 fax

### **LOS ALTOS CLINIC**

4856 El Camino Real  
Los Altos, CA 94022  
650-567-9110 phone  
650-567-9186 fax

Clinic hours: Monday – Friday, 7:30am to 5:00pm

Office hours: Monday – Friday, 8:00am to 5:00pm

## **Driving Directions to Bay Area Hyperbarics – Los Gatos Clinic**

14589 South Bascom Ave, Los Gatos, CA 95032

### **From Campbell, Saratoga, Redwood City or further north:**

- Take CA-85 south
- Take the “Los Gatos Blvd/Bascom” exit
- Turn left onto South Bascom
- Cross over CA-85
- Bay Area Hyperbarics is on the left one block from CA-85. Look for our sign.

### **From downtown San Jose:**

- Take CA-87 south
- Merge onto I-280 north
- Merge onto CA-17 south toward Santa Cruz
- Take the “Camden Avenue/San Tomas Expwy” exit
- Turn left onto Camden Avenue
- Turn right onto South Bascom
- Follow South Bascom about 0.8 miles
- Bay Area Hyperbarics is on the right. Look for our sign.
- If you reach CA-85, you have driven too far. Turn around!

### **From Morgan Hill and further south:**

- Take US-101 north toward San Jose
- Merge onto CA-85 north via exit 377A toward Cupertino/Mountain View
- Take the “Bascom Avenue” exit toward Los Gatos Blvd
- Turn right onto South Bascom
- Bay Area Hyperbarics is on the left one block from CA-85. Look for our sign.



## DRIVING DIRECTIONS TO LOS ALTOS

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### LOS ALTOS CLINIC

4856 El Camino Real  
Los Altos, CA 94022  
650-567-9110 phone  
650-567-9186 fax

Clinic hours: Monday – Friday, 7:30am to 5:00pm

Office hours: Monday – Friday, 8:00am to 5:00pm

## Driving Directions to Bay Area Hyperbarics – Los Altos Clinic

4856 El Camino Real, Los Altos, CA 94022

### From San Francisco:

- US-101 south from San Francisco.
- Take the “San Antonio Rd” (south) exit 400C off US-101. The sign will also say “Los Altos.”
- Turn left onto El Camino Real, CA-82 south.
- Look for our Bay Area Hyperbarics sign on the right. Next to Mohr’s Clocks.

### From San Jose:

- Take CA-87 north from San Jose.
- Merge onto US-101 north.
- Take the “Old Middlefield Way” exit off 101 north, Exit 399B.
- Old Middlefield becomes Middlefield Road. You will be headed west.
- Turn left onto San Antonio Road.
- Turn left onto El Camino Real, CA-82 south.
- Look for our Bay Area Hyperbarics sign on the right. Next to Mohr’s Clocks.

### From Los Gatos:

- Take CA-85 north from Los Gatos.
- Merge onto E. El Camino Real, CA-82 north.
- Take the “Old Middlefield Way” exit off 101 north, Exit 399B.
- Make a U-Turn at Showers Drive onto El Camino Real, west.
- Look for our Bay Area Hyperbarics sign on the right. Next to Mohr’s Clocks.