PATIENT INFORMATION

Lymphatic Health Center
517 Alcove Rd, Ste 101 Mooresville, NC 28117
P: 704-664-7303

NAME____AGE____ DATE_________________

1. **What is the reason for your visit?** ____
2. **List cause and date of symptoms (surgery, injury, etc)** ________________________
3. **What is your pain level *today* on a scale from 0-10. (0= no pain, and 10= worst pain ever)**? *Please circle a number below*

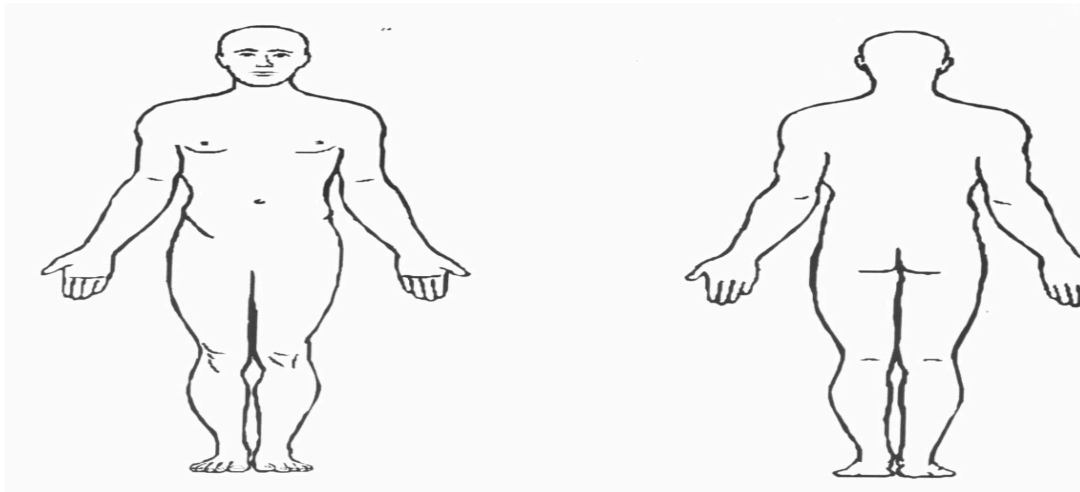
   0 1 2 3 4 5 6 7 8 9 10

5. **What makes the pain *better* (meds, exercise, elevation, compression, etc)?**

____

6. **What makes the pain *worse* (standing, sitting, walking, lying down, reaching, stretching, etc)**____

Mark any areas where you have pain with an X
Mark any areas of numbness or tingling with an O



7. Medications:

❑ See list attached ❑ See MD notes ❑ List medications below

PATIENT INFORMATION

Lymphatic Health Center
517 Alcove Rd, Ste 101 Mooresville, NC 28117
P: 704-664-7303

8. Please check if you have ever had the following:

❑ Arthritis ❑ Broken bones/fractures ❑ Seizures/epilepsy ❑ Osteoporosis

❑ Neurological disorder (MS, ALS) ❑ Cancer ❑ Ulcers/stomach problems

❑ Depression or anxiety ❑ Circulation/Vascular problems ❑ Heart problems

❑ High blood pressure ❑ Lung problems ❑ Thyroid problems ❑ Head injury

❑ Diabetes or low blood sugar ❑ Joint pain or swelling ❑ Hearing problems

❑ Infectious disease (TB, hepatitis) ❑ Loss of balance ❑ Difficulty walking

❑ Difficulty sleeping ❑ Bowel or bladder problems ❑ Weight loss or gain

❑ Other____

9. List any surgeries you have had:_______________________________________

____

10. List any allergies you have: ____

____

11. At the present time, would you say that your health is:

Excellent Very good Good Fair Poor

12. Goals for therapy: ____

Patient signature: ___________________________________ Date: _______________

Guardian Signature: __________________________________ Date: ______________

PATIENT INFORMATION

Lymphatic Health Center
517 Alcove Rd, Ste 101 Mooresville, NC 28117
P: 704-664-7303

PATIENT:

NAME________________________________DATE OF BIRTH____________

ADDRESS______________________CITY___________STATE____ZIP______

HOME PHONE____________________CEL PHONE_____________________

REFERRING MD__________________PRIMARY CARE MD______________

EMAIL____

- OK TO EMAIL? YES___________ NO____________
- PHOTO CONSENT? YES___________ NO_____________

EMERGENCY CONTACT:

NAME________________________________PHONE#___________________

RELATIONSHIP____

INSURANCE INFORMATION:

❑ COPY ON FILE (skip below section)

INSURANCE COMPANY(S)____

POLICY#________________________________GROUP#________________

FINANCIAL AGREEMENT - Lymphatic Health Center

BILLING:

We will process your insurance claims. However, **it should be understood that it is your responsibility to pay for any amounts not covered by your insurance company and to verify if we are in or out of network.**

We appreciate payment of your co-pay portion at the time of the visit in order to keep our record keeping as current as possible. We will provide you with a statement once your insurance company has processed their portion and any outstanding balance on your part.

______ (Please initial)

MEDICAID:

We ARE NOT in network with Medicaid and will not file with them. You will be responsible for your copay.

_____ (Please initial)

CANCELLATION POLICY:

We reserve your appointment time exclusively for you to best meet your schedule and ours. Therefore, we require a 24-hour notice for all cancellations. **Failure to provide a 24-hour notice of cancellation will result in a $25 fee. There is a $40 no-show fee.** These charges cannot be billed to your insurance company so these charges will become your responsibility. *In the event of two no-shows or frequent cancellations, the therapist has the right to terminate all future sessions. NO EXCEPTIONS.*

_____ (Please initial)

I have read and understand this letter and agree to the terms stated above.

Signature: ___________________________________ Date: ____________

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS -Lymphatic Health Center

I consent to the use or disclosure of my protected health information by LYMPHATIC HEALTH CENTER (LHC) for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of LHC. I understand that treatment of me by my therapist may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or other healthcare operations of the facility. LHC is not required to agree to the restrictions that I may request. However, if LHC agrees to a restriction that I request, the restriction is binding on LHC and my therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that my therapist and LHC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review LHC'S Notice of Privacy Practices prior to signing this document. The LHC Notice of Privacy Practices has been made available to me for review. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of LHC. The Notice of Privacy Practices for LHC is provided to each new patient and is also available in the waiting room area. This Notice of Privacy Practices also describes my rights and LHC'S duties with respect to my protected health care information.

LHC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal
Representative:____ Date:_____________