## Omnitherapy Center

# REGISTRATION FORM (Lymphedema)

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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | EMAIL: | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | | First: | | | | | | | | | | | Middle: | | | | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | | | | | | Marital status (circle one) | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | | | |
| Is this your legal name? | | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | Birth date: | | | | | | | | | | Age: | | | Sex: | | | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | / / | | | | | | | | | |  | | | ❑ M | | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | |
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| P.O. box: | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | | | ZIP Code: | | | | | | | | | |
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| Occupation: | | | | | | | Current work status:  \_Full time \_Part time \_Retired \_Disabled \_Homemaker \_Do not work | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer’s name, address and phone #: | | | | | | | | | | | | | |
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| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | ❑ Yellow Pages | | | | | | | | | | | | ❑ Other | | | | | | | |  | | | | | | | | | | | | | | | |
| Other family or friends seen here: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | | Birth date: | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | |
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| Is this person a patient here? | | | | | | | | | ❑ Yes | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Occupation: | | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
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| Is this patient covered by insurance? | | | | | | | | | | | | | | | | ❑ Yes | | | | | | ❑ No | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance: | | | | | | | | | | ❑ Traditional Medicare | | | | | | | | | | | | | | ❑ BC/BS of NJ | | | | | | | | | ❑ UHC | | | | | | | | | | | | | ❑ Cigna | | | | | | | | | ❑ Aetna | | | | | |
| ❑ Oxford | | | | | ❑ Clover | | | | | | | | | | | | | ❑ Auto | | | | | | | | | ❑ Worker’s Comp | | | | | | | | | | | | | | | | | | | ❑ Other: | | | | | |  | | | | | | | | |
| Subscriber’s name: | | | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | Birth date: | | | | | | | | Group no.: | | | | | | | | | | | | | | Policy no.: | | | | | | | | | Co-payment: | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | | ❑ Spouse | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | | | | Policy no.: | | | | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| What area(s) will we be evaluating and treating? : | | | | | | | | | | | | | | | | | Have you had physical therapy in the past six months elsewhere or at home? \_\_yes \_\_no | | | | | | | | | | | | | | | | | | | | | | |  | | | | EMERGENCY CONTACT INFORMATION:  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
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| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist Ana Pozzoli, PT and/or Omnitherapy Center. I understand that I am financially responsible for any balance, co-insurance or co-pays. I also authorize Omnitherapy Center or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | | | | | | | | |  |

**OMNITHERAPY CENTER**

**LYMPHEDEMA PATIENT HISTORY**

**Medical History: Please mark all conditions that apply:**

Diabetes: High Blood Pressure Cancer

Infectious Diseases (inc. HIV/Aids) Allergies Pacemaker

Trauma Lung Vascular Problems

Heart Disease Broken Bones Pregnancy

Thyroid Problems Kidney Problems Metal Implants

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight loss surgery

PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10 SEVERITY LEVEL: Mild Moderate Severe

Lymphedema of:

Right Arm Left Arm Head/Neck Right Leg

Left Leg Genital Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast surgery:

Right side (month/year\_\_\_\_\_\_) Left side (month/year\_\_\_\_\_\_\_\_) Both (month/year)\_\_\_\_\_\_\_\_\_

Lumpectomy Simple/Total Mastectomy Modified/Radical

Axillary node Sentinel Node Biopsy

Abdominal surgery:

Pelvic Resection (date:\_\_\_\_\_\_\_) Hysterectomy (date:\_\_\_\_\_\_\_\_)

Other abdominal surgeries (please list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other surgery:

Prostate surgery (date:\_\_ \_\_\_\_) Head & Neck (year:\_\_\_\_\_\_\_\_) Radiation: \_\_yes \_\_no

WEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had?

Chemotherapy # of treatments:\_\_\_\_\_ Year:\_\_\_\_\_\_\_\_\_

Radiation # of treatments:\_\_\_\_\_ Year:\_\_\_\_\_\_\_\_\_

Infections (such as: Cellulitis, Shingles) \_\_yes \_\_no

Hospitalized because of an infection? \_yes \_no; when? \_\_month \_\_year & how long?\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know how your Lymphedema developed? If so, describe how and why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Briefly, how long have you had Lymphedema?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had previous intervention/treatments for your Lymphedema? Yes No

Do you now have any pain associated with your Lymphedema? Yes No

Do you wear a compression sleeve/garment at present? Yes No

Do you have short stretch bandages? Yes No

Have you ever leaked lymph fluid? Yes No I don’t know

Have you ever been diagnosed with CHF (Congestive Heart Failure)? Yes No

Have you ever had open sores on your affected limb? Yes No

Have you ever, in your lifetime, traveled outside the United States? Yes No

Are you flying any time soon? Yes No

Do you smoke or drink? Yes No

Do you feel tired all the time? Yes No

Has your Lymphedema affected any of your relationships? Yes No

What is your daily lifting activity? Light Moderate Heavy

What tests/studies, if any, have you had done for your Lymphedema?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your present condition stopping you from doing?:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your expectations from your treatments at OmniTherapy Center?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any questions or concerns?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## omnitherapy center

**MEDICATION LIST**

DON’T FILL THIS OUT IF YOU HAVE A LIST ALREADY. PLEASE PROVIDE IT TO THE RECEPTIONIST.

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| --- | --- | --- | --- |
| MEDICATION: | DOSAGE OR AMOUNT: | FORM TAKEN (PILL, INJECTION): | FREQUENCY TAKEN: |
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## omnitherapy center

# Lymphedema Treatment Consent Form

Print Your Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Successful treatment of Lymphedema requires commitment and dedication of the patient and therapist to the therapy program. Please understand that this program is not a cure, but a maintenance program. You will be responsible for keeping your condition under control the rest of your life. Reduction of edema not only improves the quality of your life, but also decreases the incidence of severe secondary infections such as cellulitis. If you are treated at OmniTherapy Center you will be required to follow a specific program here and at home.

Most of this program will consist of:

* Daily/weekly visits for evaluation, treatment, and measurements by the therapist.
* A meticulous skin care routine.
* Manual Massage/Lymph Drainage Therapy (MLD).
* Application of Short Stretch Bandaging of the limb(s) 20 to 23 hours a day, or more depending on your therapist findings and recommendation.
* If appropriate and possible, self bandaging. You and/or your caregiver will be instructed in self-massage and self-bandaging techniques.
* Therapeutic exercises to accelerate lymph flow.
* Instruction in a home maintenance program.
* Professional recommendation and measurements for Lymphedema garments

Note: Short Stretch Bandages and garments are **not** covered by insurance; we accept: Cash, Check, Debit Card, or Visa/MasterCard when the products are dispensed.

***Please arrive on time***. Chronic lateness constitutes shorter session times and is counterproductive. We suggest arriving 5 to 10 minutes earlier than your scheduled time.

Also, please be considerate of others; call us as soon as possible if you are going to miss an appointment, ***minimally 24hrs in advance***. There are other Lymphedema patients that may be able to attend your cancelled scheduled time. Thank you in advance for your cooperation.

**\* NON-COMPLIANCE IN THE ABOVE OUTLINED PROGRAM MAY LEAD TO DISCHARGE\*.**

Are you prepared to follow such program? Yes No

**INITIAL**

## omnitherapy center

CONSENT FORM

**Authorization for release of Medical Information:**

I authorize Omnitherapy Center to release all information necessary to verify insurance benefits and/or process my insurance claims to my insurance carrier for payment of services rendered to me including the release of any pertinent information to any case worker, adjuster or employer involved in this case. I authorize the release of my medical records if needed to Omnitherapy Center by all my healthcare providers in order to coordinate my care.

**INITIAL**

**Authorization for Treatment:**

By signing this form, I am requesting and consenting to the evaluative and therapeutic procedures which may include, but are not limited to physical examination and physical therapy treatment. I hereby warrant that I have not been adjudged as incompetent. I understand that it is my right to determine the extent of my medical care, and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment. I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, procedure or therapy performed.

**INITIAL**

**Assignment of Benefits/Cancellation Fee:**

I request that payment of authorized insurance benefits be made on my behalf directly to Omnitherapy Center and/or Ana Pozzoli, PT at the current address my services are rendered. If my current policy prohibits direct payment to the provider, I direct payment be mailed to me c/o Omnitherapy Center at the address my services are rendered. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER MY POLICY. I also authorize Omnitherapy Center, LLC and/or Ana Pozzoli, PT to initiate a complaint and/or appeal to my insurance carrier or to the Insurance Commissioner on my behalf.

This is an-individual-appointment-based-physical therapy establishment, and I understand that there is a **‘cancellation fee’** of **$45.00** if I do not show-up or cancel therapy without calling this office **24 hours** in advance.

**INITIAL**

**Notice of Privacy Practices:**

The notice of privacy practices is posted in the waiting room. If you would like a copy please inform our staff and we will be happy to provide you with a copy.

**INITIAL**

**FINANCIAL POLICY**

Please note that we participate in many different insurance plans and every policy is different; it is your responsibility to get referrals, know your visit limit and dollar amount limit. We will assist you in verifying your benefits, but it is your responsibility for your co-pays, your co-insurance, deductibles or any procedures not covered by your insurance. I hereby authorize and guarantee payment for all services rendered***.***

***If I have a deductable, co-insurance or co-pay, I will make payment on the day the service is provided***. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs, court costs, attorney fees and interest accrued with the collection of this account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign (by the responsible party) Dated