## Omnitherapy Center

# REGISTRATION FORM (Lipedema)

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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | EMAIL: | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | | | First: | | | | | | | | | | Middle: | | | | |  | | | |  | Marital status (circle one) | | | | | | | | | | | | | | | | | |
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| Is this your legal name? | | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | | Birth date: | | | | | | | | Age: | | | Sex: | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | / / | | | | | | | |  | | | ❑ M | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Mobile #: | | | | | | | Home phone #: | | | | | | | | | | | | | | | | | | | |
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| Occupation: | | | | | | | Current work status:  \_Full time \_Part time \_Retired \_Disabled \_Homemaker \_Do not work | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Referred to the clinic by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | ❑ Hospital | | | |
| ❑ Family | | | ❑ Friend | | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | | ❑ Our website | | | | | | | | | | ❑ Other website | | | | | | | | | | | | | ❑ Social Media Groups | | | | | | | | |
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| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your current insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The person responsible for the bill: | | | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| Is this person a patient here? | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| Is this patient covered by insurance? | | | | | | | | | | | | | | | | | ❑ Yes | | | | | | ❑ No | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance: | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | |  | | | | | | |  | | | | |
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| Subscriber’s name: | | | | | | | | | | |  | | Birth date: | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | Policy no.: | | | | | | | | | | | | | | | | |  | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | | | ❑ Spouse | | | | | ❑ Child | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |
| 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 | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |
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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:  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
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| The above information is accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to the therapist Ana Pozzoli, PT, or Omnitherapy Center. I understand that I am financially responsible for balance, co-insurance, or co-pays. I also authorize Omnitherapy Center or the insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Patient signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | Date | | | | | | | | | | | | | |  |

**OMNITHERAPY CENTER**

**LIPEDEMA PATIENT HISTORY**

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

Diabetes High Blood Pressure Cancer

Infectious Diseases (inc. HIV/Aids) Allergies PCOS

Trauma Lung Issues Vascular Issues

Heart Disease/Pacemaker Neurological Issues Pregnancy

Thyroid Issues Kidney Issues Metal Implants

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight loss surgery Digestive Issues

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

Areas affected by Lipedema:

Right Arm Left Arm Abdomen Right Leg

Left Leg Buttocks Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

When did your Lipedema Start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been officially diagnosed with Lipedema? Yes No By Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous interventions/treatments for your Lipedema? Yes No

Do you have joint pain? Yes No

Do you bruise easily? Yes No

Does your weight fluctuate? Yes No

Have you tried dieting? Yes No

If yes, which diet did you follow?\_\_\_\_\_\_\_\_\_\_\_\_How much did you lose?\_\_\_\_\_\_\_\_\_\_

When did you notice your body was different? Chilhood Puberty During/after Pregnancy Pre Menopause Menopause

Do you have trouble finding clothing that fits properly? Yes No

Do you have trouble fitting into shoes or boots? Yes No

Do you have trouble walking? Yes No

Do you have pain with sitting?

Do you have trouble with standing? Yes No

Has your Lipedema affected any of your relationships? Yes No

Do you have women in your family that has your shape? Yes No Who?\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any special tests done? Yes\_\_\_\_ NO\_\_\_ if yes, what test?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many doctors have you seen before coming to Omnitherapy Center?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is your Lipedema condition stopping you from doing?:

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

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

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

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

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Have you ever been diagnosed with:\_\_Lymphedema \_\_\_Venous Insufficient \_\_\_Cellulitis \_\_Dercums \_\_\_Eating Disorders

\_\_Obesity

Are you pregnant? \_\_Yes \_\_No

How many children do you have? \_\_\_\_Boys \_\_\_Girls

Do you exercise? \_\_\_Yes \_\_\_No

Do you sleep well? \_\_Yes \_\_No How many hours do you sleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## omnitherapy center

**MEDICATION LIST**

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

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

# Lipedema Treatment Consent Form

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

Successful treatment of Lipedema 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 for the rest of your life. Reduction of edema not only improves the quality of your life but decreases the incidence of severe secondary infections such as cellulitis. At OmniTherapy Center, you must follow a specific program here and at home.

Most of this program will consist of:

* Visits are made by the therapist for evaluation, treatment, and measurements.
* A meticulous skincare routine.
* Manual Lymph Drainage (MLD).
* The use of appropriate garments as needed and recommended by the therapist.
* If appropriate and possible, self-MLD will be instructed.
* Therapeutic exercises to facilitate lymphatic flow.
* Instruction in a home management program.
* Professional recommendation and measurements for Lipedema garments.
* Patient and caregiver’s education for self management of the condition.

Note: Garments are **not** covered by insurance at Omnitherapy Center.

***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 48 hours in advance***. Other Lipedema patients may be able to attend your scheduled time for cancellation. Thank you in advance for your cooperation.

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

Are you prepared to follow such a 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 process my insurance claims to my insurance carrier for payment of services rendered to me, including releasing any pertinent information to any caseworker, adjuster, or employer involved. I authorize the release of my medical records to Omnitherapy Center by all my healthcare providers to coordinate my care if needed.

**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 treatment. I now 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.

**INITIAL**

**Assignment of Benefits/Cancellation Fee:**

I request that authorized insurance benefits be paid on my behalf directly to Omnitherapy Center or Ana Pozzoli, PT, at the current address where 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 where my services are rendered. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER MY POLICY. I also authorize Omnitherapy Center, LLC or Ana Pozzoli, PT, to initiate a complaint or appeal to my insurance carrier or the Insurance Commissioner.

This is an individual-appointment-based Lymphedema/Lipedema establishment. I understand there is a **‘cancellation fee’** of **$50.00** 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 gladly provide it.

**INITIAL**

**FINANCIAL POLICY**

Please note that we participate with only “Traditional Medicare” as an in-network provider. We consider all other insurance companies to be “Out-of-network” providers. We will assist you in verifying your benefits, but you are responsible for your co-pays, co-insurance, and deductibles. As a result of this, I authorize and guarantee payment for all services rendered***. If I have a deductible or co-insurance, I will make payment on the day the service is provided***. Suppose my account becomes delinquent for more than 30 days. In that case, I also agree to pay a finance charge of 2.5% 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.