## Omnitherapy Center

# REGISTRATION FORM (Lymphedema)

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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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|  | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | | | ZIP Code: | | | | | | | |
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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**

**LYMPHEDEMA PATIENT HISTORY**

**Medical History: Please check 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 History of Wounds

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 interventions/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 traveled outside the United States? Yes No

Are you flying anytime 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 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:

* Daily/weekly visits are made by the therapist for evaluation, treatment, and measurements.
* A meticulous skin care routine.
* Manual Lymph Drainage (MLD).
* The use of Short Stretch Bandaging on the limb(s) for 24 to 48 hrs, or more, depending on findings and recommendation.
* If appropriate and possible, self-bandaging techniques. You and your caregiver will be instructed in self-drainage and self-bandaging techniques.
* Therapeutic exercises to accelerate lymph flow.
* Instruction in a home maintenance program.
* Professional recommendation and measurements for Lymphedema garments.
* Patient and caregiver’s education for self managing the condition.

Note: Bandages and garments are **not** covered by insurance at Omnitherapy Center; we accept: Cash, Check, Debit Card, or Visa/MasterCard.

***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***. 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 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.