Please note our new location!

Lymphatic Health Center
142 South Cardigan Way, Unit F
Mooresville, NC 28117

704-664-7303

Patient Information

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Referring doctor: _____ Primary doctor: _____

Did you provide a copy of your insurance card?

Yes: skip to next section. **No**: complete this section.

Primary Insurance Company: _____

Subscriber's Name (if different from patient): _____

Subscriber's Date of Birth (if different from patient): _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

What brings you in for your appointment today?

Injury: _____ Date:_____

Surgery: _____ Date:_____

Other: _____ Date:_____

On a scale of 0 to 10, please circle your pain level today? 0 1 2 3 4 5 6 7 8 9 10

0 = no pain 10 = worst pain ever

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Patient Information

Please check if you have ever had the following:

- ☐ Diabetes
- ☐ Obesity
- ☐ High blood pressure
- ☐ Broken bones/fractures
- ☐ Osteoporosis
- ☐ Joint pain or swelling
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Infectious disease
- ☐ Weight loss or gain
- ☐ Other: _____
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Heart condition
- ☐ Arthritis
- ☐ Psychological symptoms (Depression, Anxiety)
- ☐ Neurological disorder (MS, ALS, Parkinson's)
- ☐ Seizures or epilepsy
- ☐ Circulation/vascular problems
- ☐ Lung problems
- ☐ Hearing problems
- ☐ Neuropathy

Please list any relevant surgeries you have had (if not included in doctor's referral) with approximate dates:

_____

_____

Please list any allergies: _____

Medications: ☐ See MD notes ☐ See attached list

Right now, is your health: Excellent Very good Good Fair Poor

Goals for therapy:

- ☐ Improved movement
- ☐ Improved strength
- ☐ Improved self-care
- ☐ Less pain
- ☐ Decreased swelling
- ☐ Prevent lymphedema
- ☐ Be more active
- ☐ Decreased scar tissue
- ☐ Wound healing
- ☐ Other: _____

Signature of patient or personal representative:

Signature: _____ Date: _____

Printed Name: _____

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Office Policies

Billing

It is your responsibility to verify if we are in OR out of network. We will process your insurance claims within 72 hours. However, it should be understood that **it is your responsibility to pay for any amounts not covered by your insurance company.**

We appreciate payment of your co-pay at the time of the visit in order to keep our records as accurate as possible. We will send you a monthly statement with any outstanding balance due.

Medicaid

We are NOT in network with Medicaid and will not file with them.

Cancellation Policy

We reserve your appointment time exclusively for your one on one treatment with our staff. While we understand emergencies happen, missed appointments cannot be billed to your insurance company, therefore these charges are your responsibility. **Failure to provide a 24-hour notice of cancellation will result in a $25 fee. Failure to come to your appointment without calling will result in a $40 no-show fee. NO EXCEPTIONS. In the event of two no-shows or frequent cancellations, the therapist has the right to terminate all future sessions.**

I have read and understand this page and agree to ALL the terms stated above.
Signature of patient or personal representative:

Signature: _____ Date: _____

Printed Name: _____

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HIPAA Consent for Purposes of Treatment, Payment and Healthcare Operations

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:

Signature: _____ Date: _____

Printed Name: _____