PATIENT REGISTRATION FORM

GENERAL INFORMATION:

Name: ______________________________ **Sex:** _________ **Birthdate:** __________________
Last First MI

Address: ____________________________ **City:** ________ **State:** ____ **Zip Code:** ________

Home Phone: ___________ **Email:** ______________ **Marital Status:** ______ **SSN:** ___________

Employer: _________________ **Employer's Address:** ____________________________________

Work Phone: ________________ **Drivers License:** ____________________ **State:** __________

Cell Phone: ____________ **Emergency Contact:** __________ **Emergency Contact Phone:** ________

Referring Physician: _________________________________ **Phone:** _____________________

Primary Care Physician: ______________________________ **Phone:** _____________________

INSURANCE INFORMATION

Primary Insurance: __________________________________ **Phone:** _____________________

Name of Insured: ______________________ **ID:** _______________ **Employer:** _____________

Group #: ______________ **Relationship to Patient:** _______________ **Birthdate:** ___________

Secondary Insurance: ________________________________ **Phone:** _____________________

Name of Insured: ______________________ **ID:** _______________ **Employer:** _____________

Group #: ______________ **Relationship to Patient:** _______________ **Birthdate:** ___________

FINANCIAL AGREEMENTS (PLEASE INDICATE PREFERENCE)
AT TIME OF SERVICE CASH_____________CHECK____________INSURANCE_____________

NOTICE OF PRIVACY PRACTICES
I have read and acknowledged the Facility's notice of privacy practices that are posted in the front waiting room. I understand that if I have questions or complaints, I may contact the Facility's Clinical Director.

Please Initial__________

AGREEMENT.........PLEASE SIGN-DO NOT PRINT!
___ I, hereby authorize treatment and supplies be rendered by the Lymphedema and Wound Care Consultants of America and their staff and assume financial responsibility for products and services furnished, as indicated above. I hereby authorize payment of medical benefits directly to Lymphedema and Wound Care Consultants of America, and further authorize the release of any medical information and records to my insurance company, physicians and or other related individuals or as necessary to process insurance claims and or initiate a complaint to the Insurance Commissioner for any reason on my behalf. I further authorize that photographs may be taken and used for clinical marketing and research by the Lymphedema and Wound Care Consultants of America. I permit a copy of this authorization to be as valid as the original. All costs of the services and supplies not paid for my insurance company will become my responsibility and accrue interest on the past due balance at a rate of 1 ½ % monthly, ninety (90) days after final payment by my insurance company. All payments shall be first applied to interest and the balance to the principal.

________________________________ ____________________
PATIENT'S SIGNATURE **DATE**

Assignment of Benefits (AOB)
This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Lymphedema & Wound Care Consultants of America, Inc. and/or any of our corporate affiliates for medical supplies and/or medication(s) furnished to me by Lymphedema & Wound Care Consultants of America, Inc.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
4. Lymphedema & Wound Care Consultants of America, Inc. and/or any of our corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided.
5. Lymphedema & Wound Care Consultants of America, Inc. and/or any of our corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone Number: ______________________________

PLEASE SIGN HERE [ ] DATE: [ ]

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Lymphedema & Wound Care Consultants of America, Inc. and/or any of our corporate affiliates for any medical supplies and/or medication(s) furnished to me by Lymphedema & Wound Care Consultants of America, Inc.
I authorize any holder of medical information about me to release to Lymphedema & Wound Care Consultants of America, Inc. and/or any of our corporate affiliates, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

YOUR MEDICARE # [ ]

Insurer: ______________________________
(Other than, or in addition to, Medicare)

Policy ID Number: ________________

Insurer Phone Number: ________________

Please correct any errors in your name and/or address below:

Lymphedema & Wound
CARE CONSULTANTS

PATIENT HISTORY

Name:	DOB:	Age:	Sex: ☐ M ☐ F	Date:

Primary Care Physician	Referring Physician	Any other Physician involved
Name:	Name:	Name:
Phone:	Phone:	Phone:
Address:	Address:	Address:
City:	City:	City:
State: Zip:	State: Zip:	State: Zip:

Surgical History

Type of Surgery	Hospital	Date/Year

Please list any other hospitalizations and why you were hospitalized: ____________________

____

Present Medications (Please list ALL medicine you are taking including over-the-counter medicines)

Medication	Strength/Dose	What condition do you take this for?

Allergies: ____________________

Patient Signature: ____________________ **Date:** ____________________

Lymphedema & Wound
CARE CONSULTANTS

MEDICAL HISTORY

Check all the following conditions you or your family has or has had at any time:

Patient: (PLEASE ONLY ELABORATE ON YOUR CONDITIONS.)	Self	Mother	Father
Alcoholism/Drug Abuse			
Anemia			
Angina/Chest Pain			
Arthritis			
Asthma/Wheezing			
Birth Defects- If yes, please describe: ______			
Bleeding Tendency			
Blood Clot/Deep Vein Thrombosis- If yes, please describe: ______			
Bronchitis/Chronic Cough			
Cancer- If yes, please list the type: ______ Have you had ☐ Chemotherapy ☐ Radiation ☐ Lymph Node Removal/Biopsy			
If you had a Lymph Node Removal/Biopsy what area of your body were the lymph nodes removed from? ______			
Cellulitis- If yes, what area of your body was affected: ______ Were you hospitalized for Cellulitis ☐ Yes ☐ No When: ______			
Cirrhosis of Liver			
Chronic Kidney Disease- If yes, what stage: ______ Are you on dialysis? ☐ Yes ☐ No How often do you receive dialysis: ______			
Chronic Venous Insufficiency			
Chronic Wound(s) If yes, please describe: ______			
Congenital Heart			
Congestive Heart Failure If yes, when was your last hospitalization: ______			
Convulsions/Seizures			
Diabetes If yes, what type: ☐ Type I ☐ Type II ☐ Prediabetes How is your diabetes controlled: ☐ Diet ☐ Oral Medications ☐ Insulin ☐ Other			
Edema/Arm Swelling			
Edema/Leg Swelling			
Emphysema			
Enlarged Heart			
Epilepsy			
Fainting Spells			
Filariasis			

Gynecological Problems			
Heart Attack(s)			
Heart Murmur			
Hepatitis- If yes, please check the type: ☐ A ☐ B ☐ C ☐ Other: ______________			
High Blood Pressure			
Jaundice			
Leg Pain When Walking- If yes, please describe: ______________			
Leukemia			
Liver Disease			
Migraines			
Neuromuscular Disorder- If yes, please describe: ______________			
Nocturia/Frequent Overnight Urination			
Obesity			
Obstructive Sleep Apnea-If yes, do you use a CPAP ☐ Yes ☐ No			
Prostate Problems			
Shortness of Breath			
Sickle-Cell Anemia			
Stroke			
Thyroid Disease- If yes, please describe type: ______________			
Trauma- If yes, please describe in detail: ______________			
Tuberculosis			
Tumor- If yes, please list the location: ______________ Was the tumor: ☐ malignant ☐ benign			
Varicose Veins- If yes, have you ever had vein stripping/other vein treatments: ______________			
Recent Weight Loss/Gain- If yes, please describe: ______________			
Do you wear a prosthesis? ☐ Yes ☐ No			

Any other information pertaining to your health you would like us to know about: ______________

____

____

Patient Signature: ______________________ Date: ______________

Lymphedema & Wound
CARE CONSULTANTS

EDEMA QUESTIONNAIRE

What area of your body is affected by swelling? ☐ Right Leg ☐ Left Leg ☐ Both Legs
☐ Right Arm ☐ Left Arm ☐ Both Arms ☐ Chest/Breast ☐ Back ☐ Abdomen
☐ Face/Head ☐ Neck ☐ Groin Area ☐ Generalized Overall Swelling ☐ Other: ____________________

In your own words please give a brief description of how or why the swelling developed:
____

How long have you had the swelling? ______ Years ______ Months Approximate Year: ______________

Have you had surgery on the affected extremity? ☐ Yes ☐ No
If yes, please list the surgery (or surgeries) you had: ____
____

Have you had an infection in the affected extremity? ☐ Yes ☐ No
Do you take prophylactic antibiotics? ☐ Yes ☐ No
Do you take benzopyrones for lymphedema? ☐ Yes ☐ No

Do you ever leak fluid from the affected extremity? ☐ Yes ☐ No

Please check and describe all previous conservative treatment methods you have tried:

☐ Elevation How often and how long do you elevate your affected extremity? ____________________
Does your swelling go down if your extremity is elevated? ☐ Yes ☐ No

☐ Exercise What type of exercise do you do? ☐ Walking ☐ Running ☐ Strength Training ☐ Cycling
☐ Yoga ☐ Aerobics ☐ High Intensity Interval Training ☐ Range of Motion Exercises ☐ Other
How many days per week do you exercise? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

☐ Compression Stockings/Socks/Sleeve(s)-What is the compression strength of your garments?
☐ 15-20mmHg ☐ 20-30mmHg ☐ 30-40mmHg ☐ I'm not sure
How often do you wear your compression garment(s)? _____________ How many hours per day? ________
Do you feel relief from wearing your compression garment(s)? ☐ Yes ☐ No

☐ Compression Orthotics-What type of Compression Orthotics do you have? ____________________
What is the compression strength of your Compression Orthotics?
☐ 15-20mmHg ☐ 20-30mmHg ☐ 30-40mmHg ☐ I'm not sure
How often do you wear your Compression Orthotics? ______________ How many hours per day? ________
Do you feel relief from wearing your Compression Orthotics? ☐ Yes ☐ No

☐ Manual Lymphatic Drainage (MLD)-Did you have MLD at a Lymphedema Center? ☐ Yes ☐ No

If yes, what Lymphedema Center and when? ______________________________

Other Past Treatment: ☐ Massage ☐ Bandaging ☐ Wraps

☐ Medication/Diuretics-If you are currently taking diuretics please list the name and dose of the medication: ______________________ Do you feel relief from taking diuretics? ☐ Yes ☐ No

☐ Lymphedema Pump-If you currently have a Lymphedema Pump where did you receive it?

____

When did you receive the Lymphedema Pump? ______________________________

What Type of Pump is it? Please list the name of the device:______________________________

How many chambers does the device have? ☐ 4 ☐ 8 ☐ Other __________

Was the Lymphedema Pump covered by your current insurance carrier? ☐ Yes ☐ No

Do you have a family history of swelling? ☐ Yes ☐ No

Have you experienced any of the following in your arms of legs? ☐ Rash ☐ Cellulitis ☐ Blisters ☐ Break-outs ☐ Leaking/Weeping ☐ Abscess ☐ Wounds

If you have a wound(s) please describe how the wound developed: ______________________________

____

How long have you had the wound(s)? ____________________

Have you had treatment for this wound(s) before? ☐ Yes ☐ No If yes, where and when?

____

Is there anything else about your swelling you would like us to know? ______________________________

____

____

____

Patient Signature: ______________________________ Date: ____________________

SOCIAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Widowed Do you have children? ☐ Yes ☐ No

Highest grade finished in school: ______________________

Are you currently: ☐ Employed ☐ Retired ☐ Disabled

If employed, what is your occupation: ______________________ Years of Employment: ________

What is your work schedule? ☐ Full-time ☐ Part-time ☐ Sick Leave

If not employed, what is your main source of income: ______________________

Do you live in a: ☐ House ☐ Apartment ☐ Mobile Home

Do you have to walk upstairs to your home? ☐ Yes ☐ No

Do you have a walking aid? ☐ Cane ☐ Walker ☐ Wheelchair

Have you ever smoked or chewed tobacco? ☐ Yes ☐ No Do you still smoke? ☐ Yes ☐ No

If yes, what is your average pack per day: ______________________

Do you use alcohol? ☐ No ☐ Occasionally ☐ Regularly

If you do use alcohol, how many drinks per week do you have? ________

Have you ever used recreational drugs? ☐ Yes ☐ No Do you still use recreational drugs? ☐ Yes ☐ No

PSYCHOSOCIAL ASSESSMENT

What is your primary language? ______________ Do you have difficulty reading English? ☐ Yes ☐ No

Do you have hearing problems? ☐ Yes ☐ No Do you have visual problems? ☐ Yes ☐ No

Who lives with you? (check all that apply) ☐ I live alone ☐ Spouse ☐ Children ☐ Parents ☐ Friend

Who helps you at home? (groceries, driving, daily activities) ______________________

Do you have daily transportation available? ☐ Yes ☐ No Who drives you to appointments? ________

How has your illness (lymphedema/wounds) affected your life and/or normal routine?

____

What is your expectation of this treatment at Lymphedema & Wound Care Consultants?

____

Patient Signature: ______________________ Date: ______________

Authorization for Disclosure of Protected Health Information

I acknowledge that the Facility will use my information for the purposes of treatment, payment, and health care operations.

I acknowledge my healthcare information will be disclosed for purposes of communicating results, findings and care decisions to my family members and others responsible for my care or designated by me.

I authorize the Facility and my physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records, including without limitation, history & physical, emergency records, laboratory reports, diagnostic reports, physician notes, progress notes, consultations, and discharge summary, during this outpatient visit to the organization which is or may be liable for payment of charges associated with my care and for all other purposes of benefit payment. If for any reason the Facility will need to release information to my employer I will authorize to do so.

I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, clinical staff, and administrative staff at the Facility, referring physicians, home health agencies, ambulance companies, and such other health care agencies involved in my care during and after treatment from the Facility.

I acknowledge that my medical records will be utilized in the Facility's (and the Facility's affiliates') utilization review, performance improvement, peer review, and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Facility may be stored electronically and made available through computer networks to Facility personnel, physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility in the area affiliated with the facility, my medical records may be made electronically available to the other facility, physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities which are not affiliated with our Facility, and affiliated facilities which do not have computerized medical records, will not be able to provide this service.

I acknowledge that I have been given the Facility's Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Facility's Office Administrator.

Please Initial: ____________

Patients Name: ______________________ D.O.B. ____________ SS# ______________

I hereby authorize ______________________ to release information to ______________________.
Facility Name/Provider Name — Name/Address of person/organization to which disclosure is to be made

Fax: ______________________ Address & Phone: ______________________

Please select the following:

- ☐ History & Physical
- ☐ Demographics
- ☐ CDT Forms
- ☐ MD Progress Notes
- ☐ Diagnostic Reports
- ☐ Measurements/ Volumetric
- ☐ Operation/Surgery Reports
- ☐ List of Medications
- ☐ Other: ______________________

Date:	I hereby certify and state that I have read, and that I fully and completely understand this Authorization for Disclosure of Protected Health Information, and that I have signed this Authorization for Disclosure of Protected Health Information, knowingly, freely, and voluntarily.
Time:	☐ Patient is medically unable to sign the Authorization for Release of Information/Healthcare Information.
	This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

Patient/Parent/Guardian/Conservator **X**	If other than patient, include relationship **X**
Spouse (if married/available) **X**	Witness (to signature only) **X**

- **Fees/Charges will comply with all laws and regulations applicable to the release of Protected Health Information. (Payment is due at time of release)**

Lymphedema & Wound
CARE CONSULTANTS

REMINDER:

Due to an overwhelming number of cancellations, effective January 1, 2011, our cancellation policy will be strictly enforced.

OUR CANCELLATION POLICY STATES:

Any time a patient does not attend their scheduled appointment, or cancels within less than 24 hours notice, they are subject to a $30.00 cancellation fee, which must be paid when the patient returns to treatment. This fee will not apply if there is a true medical reason for the patient's missed appointment.

X________________________________

PATIENT SIGNATURE

________/________/________

DATE SIGNED

16888 Hwy 3 • Webster, TX 77598 • Phone (281)338-2590 • Fax (281)338-2594

Appointment of Representative for Appeals, IRO Hearing and Complaints

This form allows the insured member to appoint a representative for an appeal, IRO Hearing or complaint.

Name of Member: ______________________________ Member Number: ________________

Print or Type

I want to allow ____

Name of person you want as your representative.

to be my representative in this appeal, IRO hearing or complaint.

I allow this person to do all of the following on my behalf for this complaint or appeal:

- Make or give any request or notice
- Present, gather or give any information
- Receive any notices or requests for information

X________________________________ Date: ________________________

Signature

Member's Address: ____

Phone Number: ________________________

Acceptance of Appointment

I, ____________________, with the ***Lymphedema & Wound Care Consultants of America, Inc.***, an outpatient rehabilitation specialty group practice for ***Abdul Moosa M.D., Michael Streitmann M.D., Rebecca Reilly-Nivers D.P.M., Joey Adolf D.C.,*** accept the above appointment. I am the ***Physician - Provider Patient Advocate*** of the member and provide assistance to the lymphedema patient.

X ____ ____________________________

Representative Signature *Date*

16888 Highway 3	Webster,	TX	77598	281-338-2590
Address	*City*	*State*	*Zip*	*Phone Number*

What to expect at your Evaluation

- The first visit with Lymphedema & Wound Care Consultants of America, Inc. is a comprehensive evaluation that will take approximately 2 to 3 hours. Your visit may take longer if you need specialized care of have complex wounds.
- Things that would be helpful to bring to your evaluation include your medication list, driver's license, and insurance information/insurance cards. If you've had previous labs or tests (such as a Venous Doppler Ultrasound) please attempt to bring a copy of the record. If you have medical records that pertain to your condition and/or a list of previous treatment methods that you have tried to manage your swelling this too would also be helpful.
- Due to CDC regulations and limited waiting room space, we would greatly appreciate if you would limit your attending guests to 1 person if you need assistance with ambulation, transferring, undressing, and dressing.
- Your medical history and registration forms will need to be filled out prior to your examination. All paperwork may be sent to you prior to your appointment via mail or email. These forms are also available on-line on our website at www.lymphedemaconsultants.com under the forms tab. You may fill out all forms upon arrival but please be advised this could result in a longer visit/wait time.
- Your evaluation will begin with an in-depth medical history that will include any previous medical, treatment and/or surgical history as well as a review of systems.
- Limb volume measurements will be taken. New exams must have both limbs measured even if only one is affected to determine a percentage difference.
- Pictures of the affected limb(s) and/or region of the body will be taken. To evaluate the entire affected area(s) you will be required to disrobe. Please wear loose fitting clothing to make this process faster and easier. Medical robes will be provided.
- If you have a wound(s) a wound assessment will be performed including cleaning of the wound, measurements, and pictures. Once the Physician evaluates you there may be an application of medication and/or debridement if necessary. Lastly all wounds will be dressed.
- Other tests may also be performed on an as needed basis, dependent on what the preceding parts of your examination may have revealed. These include: Venous Doppler Ultrasound (to be scheduled at a later date), Vasopneumatic compression pump trial, range of motion testing by goniometer, and metabolic testing to assist with diet counseling and education throughout the duration of your treatment. (See special instructions for this test)
- After the examination, we will answer any questions you might have. If you have concerns regarding your insurance coverage and/or benefits please speak with a Billing Specialist at 281-724-0984.

Evaluation appointments with Lymphedema & Wound Care Consultants of America, Inc. are very thorough. We strive to give every patient the ample amount of time they deserve. We understand that wait times are unpleasant, and we kindly appreciate your patience. Thank you for choosing Lymphedema & Wound Care Consultants, Inc. as your Provider.

16888 Hwy 3 • Webster, TX 77598 • Phone (281)338-2590 • Fax (281)338-2594