LymphedemaMD of America, LLC
5410 Fredericksburg Rd., Suite 102
San Antonio, Texas 78229
(210) 702-3401 Fax (210) 702-3402

PATIENT REGISTRATION FORM

Patient: _____ DOB: _____ Date:_____

Male _____ Female_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Primary Care Provider: _____

Employer Name: _____Employer Address: _____

Social Security No.: _____Marital Status: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____Cell Phone: _____

Insurance Carrier: _____Policy Number: _____Group:_____

Do you expect your insurance provider to change within the next 90 days? Yes_____ No_____

We will need a copy of your insurance cards and a copy of your picture identification for our records.

I consent to LymphedemaMD of America, LLC contacting my referring medical doctor for further information or clarification on issues pertaining to my lymphedema or underlying conditions.

Name: _____

Signature: _____ Date:_____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND/OR ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to LymphedemaMD of America, LLC (hereinafter "LMD"), a healthcare provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for healthcare services, medical services, treatments, therapies, medications and/or durable medical equipment rendered or provided by LMD, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize LMD to release all medical information necessary to process my claims. Further, I hereby authorize and direct my plan administrator, fiduciary, insurer, and/or attorney to release to LMD any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from LMD or its attorneys in order to claim such medical benefits and/or insurance reimbursement. I also hereby authorize and direct my plan administrator, fiduciary, insurer, and/or attorney to issue payment check(s) directly to LMD for the medical expenses incurred as a result of the healthcare services, medical services, treatments, therapies, medications, and/or durable medical equipment I receive from LMD.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to LMD any legal and/or administrative claim or chose in action arising under any group health plan, employee benefit plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the healthcare services, medical services, treatments, therapies, medications, or durable medical equipment I receive from LMD (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of any ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by the assignment and designation of authorized representative to convey to LMD all of my rights to claim (or place a lien on) the medical benefits related to the healthcare services, medical services, treatments, therapies, medications and/or durable medical equipment provided by LMD including any rights to any settlement, insurance or applicable legal or administrative remedies (including all damages arising from ERISA breach of fiduciary duty claims). LMD is given the right by me to (1) obtain information regarding the claim to the same extent as me, (2) submit evidence, (3) make statements about facts and/or law, (4) make any request including providing and receiving notice of appeal proceedings, (5) participate in any administrative and/or judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, and/or plan administrator. LMD as my assignee and my designated authorized representative may bring suit against any health care benefit plan, employee benefit plan, plan administrator, insurance company and/or any such liable party in my name with derivative standing at the provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), Medicare, and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Name Date

_____

Signature

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Financial Responsibility

I have been referred by a physician for occupational therapy. I know and understand that I have the right to choose any occupational therapist to treat me. I have requested healthcare services from LymphedemaMD of America, LLC on behalf of myself, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be charged for all healthcare services, medical services, treatment, therapies, medications, and/or durable medical equipment provided by LymphedemaMD of America, LLC. I understand I am responsible for all fees, regardless of insurance coverage. I further understand that all fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the billing statement. Necessary forms will be completed to help expedite insurance carrier payments. I further understand LymphedemaMD of America, LLC may choose, for my convenience, to provide me with my billing statement after payment has been made by my insurance provider.

Name: _____

Signature: _____ Date: _____

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HIPAA RELEASE OF PATIENT MEDICAL RECORDS

To: LymphedemaMD of America, LLC
5410 Fredericksburg Rd., Suite 102
San Antonio, Texas 78229

RE: Patient: _____

Date of Birth_____ Social Security Number_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with my healthcare to LymphedemaMd of America, LLC. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs, videotapes, telephone messages, and records received by other medical providers.

All physical, occupational and rehab requests, consultation and progress notes.

All laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve condition study, echocardiogram and cardiac catheterization results. All pharmacy prescription records.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health, and alcohol and drug abuse. I authorize the release or disclosure of this type of information with the exception of

_____ .

This protected health information is disclosed for the following purposes: CONTINUATION OF CARE.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records; the restrictions of which have been specifically considered and expressly waived.

I understand the following:

A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released upon this authorization/
B. The information released in response to this authorization may be re-disclosed to other parties.
C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which this authorization expires.

Name: _____

Signature: _____ Date: _____

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LymphedemaMD

PATIENT INFORMATION SHEET

Patient: _____ Date: _____ DOB: _____

Completed By: ☐ Patient (listed above) ☐ Other: _____

Where do you currently experience swelling/lymphedema? (Please circle all that apply)

Right Arm Left Arm Both Arms Breast Genital Right Leg Left Leg Both Legs Head & Neck

Other, please explain: _____

Have you been diagnosed with Lymphedema? ☐ Yes ☐ No
If yes, by whom? _____

Describe how/when your swelling developed: _____

_____

Do you have difficulty with any of the following: (Please check all that apply)
☐ Walking ☐ Dressing ☐ Reaching Feet and Toes ☐ Bathing/Showering ☐ Preparing Meals ☐ Other
If other, please explain: _____

Have you had previous treatment for swelling? ☐ Yes ☐ No (If yes, check all that apply)
☐ Manual Lymph Drainage ☐ Compression Pump ☐ Compression Garment ☐ Bandaging ☐ Lymphedema Exercise
☐ Other If Other, explain: _____

If previous treatment for swelling was received, was it successful/unsuccessful? Explain.

_____

Do you currently wear a compression garment? ☐ Yes ☐ No
If yes, how often do you wear it? _____ How old is it? _____

Do you exercise regularly? ☐ Yes ☐ No
If yes, please describe: _____

What Is Your Current Living Situation

[ ] Alone: Home Apartment # Steps:	[ ] Skilled Nursing Facility (SNF)	[ ] Assisted Living Facility (ALF)
[ ] Home or Apt. w/assistance # Steps: Asst. By:	[ ] Other, Explain:	

Do you have help from family/friends at home? ☐ Yes ☐ No If yes, WHO? _____

Are you familiar with Lymphedema precautions? ☐ Yes ☐ No

Have you had an ultrasound to rule out blood clots within the last 6 months? ☐ Yes ☐ No

LLIS Lymphedema Life Impact Scale

version 2

Patient Name _____ **Eval** _____ **10th visit** _____ **20th visit** _____ **30th visit** _____ **D/C** _____

Listed below are symptoms or problems reported by many individuals with lymphedema. Please indicate to what extent these problems associated with your lymphedema has affected you in **the past week**. Circle the number which best describes your symptom level.

I. Physical Concerns (NOTE: If swelling and symptoms are the same in both limbs, rate them the same; otherwise, rate only the worst limb)

1. The amount of pain associated with my lymphedema is:	0 no pain	1	2	3	4 severe pain
2. The amount of limb heaviness associated with my lymphedema is:	0 no heaviness	1	2	3	4 extremely heavy
3. The amount of skin tightness associated with my lymphedema is:	0 no tightness	1	2	3	4 extremely tight
4. The size of my swollen limb(s) seems:	0 normal size	1	2	3	4 extremely large
5. Lymphedema affects the movement of my swollen limb(s):	0 normal movement	1	2	3	4 extremely limited
6. The strength in my swollen limb(s) is:	0 normal strength	1	2	3	4 extremely weak

II. Psychosocial Concerns

7. Lymphedema affects my body image (how I think I look):	0 not at all	1	2	3	4 completely
8. Lymphedema affects my socializing with others.	0 no interference	1	2	3	4 interferes completely

II. Psychosocial Concerns (cont.)

9. Lymphedema affects my intimate relations with spouse or partner (rate 0 if not applicable).	0 no interference	1	2	3	4 interferes completely
10. Lymphedema "gets me down" (i.e., I have feelings of depression, frustration, or anger due to the lymphedema).	0 never	1	2	3	4 constantly
11. I must rely on others for help due to my lymphedema.	0 not at all	1	2	3	4 completely
12. I know what to do to manage my lymphedema.	0 good understanding	1	2	3	4 no understanding

III. Functional Concerns

13. Lymphedema affects my ability to perform self-care activities (i.e., eating, dressing, hygiene).	0 no interference	1	2	3	4 interferes completely
14. Lymphedema affects my ability to perform routine home or work-related activities.	0 no interference	1	2	3	4 interferes completely
15. Lymphedema affects my performance of preferred leisure activities.	0 no interference	1	2	3	4 interferes completely
16. Lymphedema affects the proper fit of clothing/shoes.	0 fits normally	1	2	3	4 unable to wear
17. Lymphedema affects my sleep.	0 no interference	1	2	3	4 interferes completely

IV. Infection Occurrence

18. **In the past year**, I have become ill with an infection in my swollen limb requiring oral antibiotics or hospitalization.	0	1x	2x	3x	4+