Space Coast Lymphedema Clinic, LLC
7000 Spyglass Ct, Suite 120, Viera, FL 32940 P-321-241-6543 F-321-241-6513

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient's Last Name: ______________________ First: ______________________ MI:______

ARE YOU CURRENTLY ON HOMECARE OR HAVING PT/OT? YES__________ NO___________
IF YOU ARE ON HOMECARE THERE WILL BE A $75 CHARGE FOR THE VISIT DUE AT TIME OF SERVICE. INSURANCE WILL NOT PAY FOR YOUR VISIT IF YOU ARE ON HOMECARE OR BEING TREATED FOR PHYSICAL OR OCCUPATIONAL THERAPY.

Home Phone #: ______________________ Cell Phone #: ______________________

Address: ______________________ City: ______________ State:_____ Zip:________

Email Address: ______________________

DOB:______________ Age:__________ Male______ Female______ SSN:______________

Married:______ Single:_______ Divorced:_______ Widowed:_______ Other:______________

Employer/Occupation: ______________________ Phone#:______________

Spouse:______________________ Phone#:______________

Emergency Contact if not Spouse:______________________

Relationship:______________________ Phone#:______________

Referring Physician:______________________ Primary Care Physician:______________

Primary Insurance: ______________________ Secondary Insurance: ______________

Insured's Name:______________________ DOB:______________

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment to assume the cost of interest, collection and legal actions (if required).

2. I authorize my insurance carriers to release information regarding my coverage to Space Coast Lymphedema Clinic, LLC. I also authorize agents of any hospital, treatment center or previous physicians to furnish Space Coast Lymphedema Clinic, LLC. Copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and or reports related to my treatment to any federal, state, or accreditation agency, or any physician, insurance carrier, suppliers/vendors for needed DME and garments. I also agree to a review of my records for purpose of internal audits, research and quality assurances revises with Space Coast Lymphedema Clinic, LLC.

3. My rights to payment for all supplies, therapist services including major medical benefits are hereby assigned to Space Coast Lymphedema Clinic, LLC. This agreement covers any and all benefits under Medicare, other government sponsored programs and private insurance and any other health plan acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payment to Space Coast Lymphedema Clinic, LLC.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read the above statement and accept the terms. A copy of this statement is considered the same as original.

Patient Signature: ______________________ Today's Date:______________

Space Coast Lymphedema Clinic, LLC

Consent to Physical/Occupational Therapy Treatment

I, ______________________________ ("Patient") acknowledged and understand that a therapist of Space Coast Lymphedema Clinic, LLC, has recommended that I receive therapy.

I further acknowledge that the purpose of the therapy and care, reasonable alternative forms of therapy, risks of the recommended and alternative care and risks of foregoing this care have been fully explained to and understood by me.

I recognize that the practice of physical and occupational therapy is much as art as science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy.

I also recognize that physical or occupational therapy care may involve the touching of my body by a therapist and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me.

I agree to cooperate fully and to participate in all physical or occupational care procedures, to comply with the plan of care as it is established and to pay Clinic's charges for such care upon my receipt of Clinic's invoice for such care.

I have read the above and I certify that I have had an opportunity to discuss the contents thereof to my satisfaction. By signing below, I am hereby consenting to the physical/occupational therapy care described above to be performed by therapist or other members of SCLC, LLC professional staff, as determined by therapist from time to time.

Permission to use Photographs: I grant SCLC, LLC its representatives and employees the right to take photographs of me in connection with the treatment that is completed during Complete Decongestive Therapy. I authorize before, during and after treatment photos. SCLC, LLC may use, print and/or electronically download for documentation purposes as well as use such photographs of me with or without my name and for any lawful purpose, including for example, illustration, and documentation purposes. **Permission granted / Yes_____ No_____**

Acknowledgment of Notice of Privacy Practices

I have reviewed a copy of SCLC's Notice of Privacy Practices. A copy of this notice is available upon my request.

Patient No-Show and Cancellation Policy

We strive to provide excellent and prompt medical care to our patients. In order to be consistent with this, we have adopted a Patient No-Show and Cancellation Policy for our clinic. When an appointment is scheduled, that time has been reserved for you and when it is missed or canceled on short notice, that time cannot be used to see another patient. Our policy is as follows: You may cancel and reschedule your appointment up to 1 business day before the scheduled appointment with no consequences. If you miss your appointment or cancel less than 1 business day before your appointment, SCLC reserves the right to bill you $25.00 for each no-show or late cancellation. This fee is the patient's responsibility and is not billable to insurance. We do realize that, on occasion, emergencies or circumstances may arise beyond your control. We will address these situations with you should that occur.

Additionally, if a patient is more than 15 minutes late to the appointment without prior notification, we reserve the right to cancel the appointment and the cancellation fee will apply. If you have any questions regarding this policy, please direct them to the practice administrator. We thank you for working with us to ensure that we are able to provide the best service possible to our patients.

I have read and understood the following: **Consent to Physical/Occupational Therapy Treatment**

Acknowledgment of Notice of Privacy Practices

Patient No-Show and Cancellation Policy

Patient Signature: ____ **Date:**____________________

Space Coast Lymphedema Clinic, LLC
7000 Spyglass Ct., Ste 120 – Viera, FL 32940

Patient History

Name: ______________________ DOB:____________ Today's Date:____________

Medical History: Please select any condition(s) that apply to your medical history:

Angina______________ Arthritis______________ Location____________
Cancer______________ Location______________________
Colitis______________ Congestive Heart Failure__________ COPD______________
Coronary Artery Disease ____________ Diabetes______________
Heart Disease ______________ High/Low Blood Pressure______
Renal Insufficiency______________ Stroke______________
Ulcer ______________ Venous Insufficiency__________
Wounds______________
Other____

Surgical History: Please check all that apply:

	Date		Date
Arthroscopic Surgery	______________	Axillary	______________
Back Surgery	______________	Coronary Bypass	______________
C-Section	______________	Gall Bladder	______________
Joint Replacement	______________	Mastectomy	______________
Neck Surgery	______________	Foot Surgery	______________

Other ____
Height: ______________________ Weight: ______________________

List Medications: (If you have a list we can make a copy for your file)

____
____

Have you fallen in the past year? Yes___ No___
Do you smoke? Yes___ No___
Are you depressed? Yes___ No___
Do you feel threatened by anyone? Yes___ No___
When did your lymphedema first occur? ______________________
Have you had previous PT or OT services this year for any condition? ______________

Please explain:____

Therapist Signature:______________________________ Date:____________
Patient Signature:______________________________ Date:____________

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

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II. Psychosocial Concerns (cont.)

Item					
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

Item					
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

Item					
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+

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