



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

Patient's Last Name \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

ARE YOU CURRENTLY ON HOMECARE OR HAVING PT/OT SERVICES? YES \_\_\_\_\_ NO \_\_\_\_\_  
**IF YOU ARE ON HOMECARE THERE WILL BE A \$75.00 CHARGE FOR THE VISIT DUE AT TIME OF SERVICE**  
**INSURANCE WILL NOT PAY FOR YOUR VISIT IF YOU ARE ON HOMECARE OR RECEIVING PHYSICAL THERAPY OR OCCUPATIONAL THERAPY.**

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ IF VETERAN PLEASE PROVIDE LAST 4 SSN \_\_\_\_\_

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Other: \_\_\_\_\_

Employer/Occupation \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Phone: \_\_\_\_\_

Emergency Contact if not spouse: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

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 treatments, 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 the purpose of internal audits, research and quality assurance 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, private insurance. Any other health plan acknowledges 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 WILL REMAIN IN EFFECT INLESS 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 the original.

Patient Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_