Lymphatic Therapy, Inc.

Expert Care for Lymphedema & Chronic Swelling

6841 South Eastern Ave Ste 100. Las Vegas, NV 89119

Phone: 702-367-6015 Fax: 702-367-0614

Email: ltsinc2@yahoo.com

www.lymphnevada.com

Patient / Insurance Information

Patient Name: _____ Date: _____

Address: _____Apt#: _____

City: _____ State: _____ Zip: _____

(Check Preferred Method)

Phone: (Home) _____ Cell: _____

Birth Date: _____ SS#_____ Sex: M F

Marital Status: Single Married Divorced Widowed

Employer: _____

Emergency Contact: _____ Phone: _____

Spouse Name: _____ Birth Date: _____

Spouse's SS#_____

Referring Physician: _____

Diagnosis: _____ Date: _____

Primary Insurance: _____

Policy Holder's Name: _____

Birth Date: _____ Relation to Patient: _____

SS#_____

Secondary Insurance: _____

Policy Holder's Name: _____

Birth Date: _____ Relation to Patient: _____

SS#_____

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Scheduling Policy

- If an appointment is not cancelled at least 24 hours in advance by phone call or voicemail, Lymphatic Therapy, Inc. will charge you $30 fee for a "no call" or a "no show." This will not be covered by your insurance company.

Consent for Treatment

- I acknowledge that my physician has referred me to Lymphatic Therapy, Inc. for evaluation and treatment. During the course of the evaluation, the goals and risks for my treatment will be discussed and a plan will be made by the evaluating therapist and me.

Release of Medical Records

- I hereby authorize Lymphatic therapy, Inc. to release any and all information contained in my medical record to the referring physician and/or insurance companies or any other agencies to which claims are made for coverage, and to the designated emergency contact**.**

Assignment of Benefits

- I hereby assign and authorize payment directly to Lymphatic Therapy, Inc. for any and all medical benefits for services provided by Lymphatic Therapy, Inc. I understand that I am financially liable to Lymphatic Therapy, Inc. for any services not covered by my insurance carrier**.**
- If I receive any reimbursement payment from my insurance company during or after my treatment at to Lymphatic Therapy, Inc. I will notify to Lymphatic Therapy, Inc., so plans can be made to reimburse Lymphatic Therapy, Inc. for my treatment or a bill will be sent for recoupment.

_____ _____

Signature of Consenting Patient/Guardian **Date**

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NOTICE REGARDING SCHEDULING WITH THERAPISTS

Your first visit at Lymphatic Therapy, Inc. is an evaluation and will be performed by one of our therapists. Your therapy may or may not be scheduled with the therapist who did your evaluation or consistently be with the same therapist. While we make every attempt to schedule you with the same therapist for each visit, it is not always possible. If you are unable to keep any schedule appointments or need to change an appointment, please notify our office as soon as possible so that we might attempt to fill your spot with another patient.

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NOTICE REGARDING PHYSICAL ASSISTANCE

During your treatment and care at Lymphatic Therapy, Inc therapists and staff are unable to assist with helping the patient into or from the bed or car, providing leg lifting assistance into or from the bed or car, and taking medical equipment or any personal belongings from a car. If possible, please bring someone with you to assist you during your treatment with Lymphatic Therapy, Inc.

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Financial Policy

Our commitment is to provide the very best medical care to our patients while recognizing the needs to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our front staff regarding any questions about our fees, financial policies or your insurance coverage and your financial responsibilities.

Patient Payments: Co-Pays, deductibles and services not covered by your insurance plan or outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having financial problems and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our front staff.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays.

Additional Fees:

Missed Appointments: Please understand that when you reserve an appointment with one of our therapists, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all of our patients with appropriate access to our therapists we may charge a $30 fee for any office visit appointment cancelled with less than a 24 hours' notice. Please note this fee is not covered by your insurance company.

Medical Supplies: Please note that certain medical supplies given to you at your visit are not covered by your insurance and require an advanced payment from you at check out. We will submit any charges from medical supplies to your insurance company, and we will reimburse you the payment difference made by your insurance company.

_____ _____

Signature of Consenting Patient/Guardian **Date**

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PHOTO CONSENT

I, the undersigned, hereby give Lymphatic Therapy Services, Inc. my permission to photograph such parts of my person as may be deemed fit, primarily for medical documentation and progress.

I acknowledge that permitting use of the photographs certain confidential medical information may be included and I hereby consent to disclosure of this information.

I have entered into this agreement in order to assist medical documentation, progress, treatment, and hereby wave any right to compensation for such uses.

The term "photograph" is used in the foregoing agreement shall mean motion picture or still photography in any format as well as video-tape, video disk, or any other mechanical means of recording and reproducing images.

All photographs are to remain the property of the clinician or clinic named herein, and will not be posted on any social media.

_____ _____

Signature of Consenting Patient/Guardian **Date**