Edema Partners

PATIENT INFORMATION

Name (first) (middle initial) (last) (suffix):_____

Nickname:_____

Sex: MALE FEMALE

Date of Birth: _____/_____/_____

Social Security Number:_____-_____-_____

Address:_____

City:_____State:_____Zip:_____

CONTACT

Phone:(____)_____-_____

Email:_____

Other:_____

EMERGENCY CONTACT

Name:_____

Phone:(____)_____-_____

Relationship:_____

PRIMARY CARE PHYSICIAN_____

Do we have permission to contact your doctor regarding the care in our office? YES NO

HIPAA (Federal Privacy Act)

Please initial ONE of the following options and sign below.

A. I wish to receive a paper copy of the HIPAA Privacy Notice. _____ (Initial)
B. I do not request a copy of the HIPAA Privacy Notice, but I acknowledge that I can request a copy at any time. _____ (Initial) __

I acknowledge that it is the policy of this office to leave reminder messages on my voicemail or with another person in my home. I may request an alternate means of communication, such as text or email.

Please specify whom we may speak to regarding your care at Edema Partners, such as a spouse, adult child, friend or partner._____

_____

Signature of Patient/Guardian:_____Date:_____

Edema Partners

Witness (Office Staff):_____Date:_____

Edema Partners

MEDICAL HISTORY

Circle your level of pain: **0 1 2 3 4 5 6 7 8 9 10**

Have you been diagnosed with Lymphedema? YES NO If yes, by whom:_____

How long have you had swelling/Lymphedema?_____

Was there a triggering event which caused the swelling/Lymphedema?_____

Please describe briefly how and why your swelling/Lymphedema developed:_____

_____

Do you wear compression? YES NO _____

Have you had any falls in the last year? YES NO _____

Have you had any surgery? YES NO _____

Have you had lymph nodes removed? YES NO _____

Have you ever received radiation therapy for cancer? YES NO _____

Have you ever had Chemotherapy? YES NO If yes, how long ago?_____

Is there a family history of Lymphedema? YES NO If yes, please explain:_____

At the time you are completing this, are you, or is there a chance you could be pregnant? YES NO

Do you currently have home health? YES NO

Do you currently suffer from (or have you had) any other the following?

Asthma	Hypothyroidism	Recent Surgery
Cellulitis	Kidney Failure/Disease	Unexplained Pain
Difficulty Breathing	Type 2 Diabetes	Deep Venous Thrombosis (blood clot)
Irregular Heart Beat	Crohn's Disease	Depression
Heart Edema	Diverticulitis	Congestive Heart Failure
High Blood Pressure	Pulmonary Embolism	

Other:_____

Allergies:_____

Patient's Signature:_____Date:_____

Reviewed with patient? YES NO

Therapist's Signature:_____Date:_____

Patient:_____ Date:_____

Lower Extremity Functional Scale (LEFS)

Circle your level of pain: 0 1 2 3 4 5 6 7 8 9 10

Today, do you or would you have any difficulty at all with: (Circle one on each line)

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or supporting activities.	0	1	2	3	4
c. Getting in and out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
I. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of your car.	0	1	2	3	4
k. Walking two blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

LLIS - Lymphedema Life Impact Scale

Patient Name_____ **Date**_____

Listed below are symptoms or problems reported by many individuals with lymphedema. Please indicate to what extent these problems associated with your lymphedema have affected you in **the past week.** Circle the number which 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) is:	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 movement extremely limited
6. The strength of 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
9. Lymphedema affects my intimate relations with my spouse or partner (rate 0 is 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+

Edema Partners

CONSENT

CONSENT TO TREAT

I, the undersigned, hereby consent to and authorize the administration of all treatment and therapies that may be considered advisable and/or necessary in the judgment of my therapist.

This authorization shall remain in full force and effect for this and future outpatient visits.

RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records to my insurance company, physicians/primary care provider or other providers that are managing my care.

PHOTO RELEASE

I hereby authorize Edema Partners (EP) to take photographs of appropriate parts of my body to provide supporting documentation of my medical condition. I understand that any photographs taken will be placed in and remain part of my medical record. I hereby authorize EP to use photographs of me, without identifying me, for educational and or publicity purposes.

COOPERATION WITH TREATMENTS

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist. I understand that my therapist will share with me her opinions regarding potential results of therapy treatment for my condition and will discuss all treatment options with me.

I WILL INFORM MY THERAPIST OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO HAVE AN EVALUATION OR TO BE TREATED. I HEREBY REQUEST AND CONSENT TO THE EVALUATION AND TREATMENT TO BE PROVIDED BY THE THERAPIST.

Patient's Name (Please Print):_____

Patient's Signature:_____Date:_____

Edema Partners

PAYMENT POLICY

OFFICE PAYMENT POLICY

We are glad you chose us to assist you in managing your lymphedema or other chronic swelling. Your health is our primary concern, and we will strive to provide you the most up to date and proven therapy program for this condition. In order to make the handling of your financial obligations as smooth as possible, please read and sign the following office policy. If you have any questions, our staff will be glad to assist you.

BILLING POLICY

If your insurance has a co-pay, you will be required to pay the co-pay prior to each visit. EP will bill your insurance directly once you have satisfied your deductible. You are responsible for the co-insurance based on what we bill your insurance. If EP does not receive payment from your insurance company within 45 days from date of service, you will be financially responsible for the remaining balance. EP is committed to working with our clients to arrange acceptable payment options. We offer payment plans with no interest. Please talk to our therapist. If no arrangements have been made, then monthly interest of 1.5% will be applied to the balance.

INSURANCE BILLING POLICY

I certify that I (or my dependent) have insurance coverage with _____ and I authorize, request, and assign my insurance company to pay directly to the practice, EP, insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all the insurance claims including electronic submissions.

MEDICARE PAYMENT POLICY

EP is a Medicare provider and we will file claims with Medicare for your treatments at EP. If you have a Medicare supplement or secondary insurance, often your claim will be automatically forwarded by Medicare to your other insurances. If this does not occur, you will be responsible for payment of the 20% of fees not covered by Medicare and you will need to seek reimbursement from your supplemental or secondary insurance. You are also responsible to pay for any Medicare deductibles or co-payments that are not covered by your supplemental or secondary insurance.

I have read and fully understand EP's financial responsibility. I acknowledge full financial responsibility for services rendered by EP and its professional staff.

Patient's Name (Please Print):_____

Patient's Signature:_____Date:_____