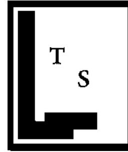
Rebecca Summers, OT, CLT-LANA, CSR
Licensed Occupational Therapist
Certified Lymphedema Therapist
Lymphology Association of North America-certified



Lymphedema Therapy Source, PLLC
309 W. Eldorado Pkwy, #108
Little Elm, Tx 75068
214-422-8265
214-614-9352 fax

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INSURANCE PAY			
Name: **Sex:**		**Date of Birth:**	
Email:		**Phone:**	
Home Address:		**Driver's License/ID:** **Insurance Cards:**	Upload a PHOTO COPY front & back of your driver's license & insurance cards. These are required for billing & benefit coverage verification.
Social Security No.:		**Physician Name:**	
Emergency Contact:		**Physician Phone:**	
Relationship:		**Physician Fax:**	

Patient Rights & Responsibilities

______ I understand **I have a right to**: respectful & considerate treatment; obtain service without regard to race, creed national origin, sex, age, disability diagnosis or religious affiliation; make informed decisions about my care; voice grievances without fear of termination of service or other reprisal in the service process; (subject to applicable law) confidentiality of all information pertaining to my service. I understand individuals or organizations not involved in my care may not have access to my information without my written consent. **I am responsible for**: notifying LTS (herein known as "LTS") of any changes to my address or phone number; changes concerning my physician or insurance; equipment failure or damage (as applicable). I am responsible to notify LTS if home health is (or plans to begin) providing service**.**

_____ **I agree to** be contacted by phone & for protected health information to be left in a message in that format.

_____ **I agree to** be contacted by email & for protected health information to be sent in that format.

Do Not Resuscitate

Type "I do" or "I do not" in this blank: _______ to indicate if you have a DNR form. If *I do have* a form, I will provide a copy to LTS prior to my first treatment session. If *I do not have* a form *or have not provided one* to LTS, I understand resuscitation will be attempted in the event of a life threatening situation.

Consent to Treatment

______ I consent to medical treatment by LTS for the diagnosis & treatment of a physical condition I may have.

Supplies

______ I am responsible for having all supplies cleaned, air dried, & rolled - ready for treatment before my appointment. If I am not prepared for my appointment, I will be asked to reschedule & may be subject to a no-show fee. It is not my therapist's responsibility to roll my bandages & not billable time to my insurance.

Acknowledgement of Privacy Notice

______ LTS is committed to protecting the privacy & security of confidential health information for this therapy practice as set forth in the Health Insurance Portability & Accountability Act (HIPAA). I acknowledge that this "Notice of Privacy Practices" has been made available to me. It can be found at https://ltstherapy.com/patients/.

HIPAA Privacy Authorization for Use or Disclosure of Medical Information

______ I authorize LTS to disclose my health information to my physician (or other medical professionals involved in my medical care) for treatment plan or medical purposes. I also authorize my physician (or other healthcare provider) to release my complete medical record for the purpose of providing therapy treatment. I understand my medical record may include but not be limited to diagnostic reports, surgery reports, lab values, drug & alcohol abuse & any communicable diseases such as HIV or AIDS. This authorization shall be in effect for one year after termination of therapy services. I understand that I may revoke this authorization (in writing) at any time.

Patient Name: ______________________________ Guardian/POA: ______________________________ (attach proof)

Signature: ______________________________ Date: ______________________________

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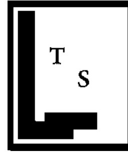

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FINANCIALS

Initial each blank. Sign & date at the bottom.

Explanation of Benefits
______ If I have been given my insurance benefits, I fully understand my responsibility. LTS is not responsible for misquoted insurance benefits. I understand that I am encouraged to contact my insurance company to verify my benefits. My primary insurance is __________. My secondary insurance is _____________. If for wound care supplies, I understand a 3rd party vendor may contact me regarding coverage.
Billing Consent, Good Faith Estimate, Card on File, & Assignment of Benefits
______ I authorize the release of any medical or other information necessary to process claims. I request payment of benefits to LTS for services provided & claimed for <u>in or out-of-network</u> coverage. This authorization applies to all occasions of services until it is revoked. If LTS is <u>out-of-network</u> with my insurance, I may be asked to pay for service at the time rendered. In such case, I request payment of benefits be made to me. If wound care supplies are billed to insurance, I authorize payment be made to the 3rd party vendor responsible. **After my evaluation**, *I will be provided a good faith estimate based on my plan of care*. *This is an estimate & may change*, but it is a reasonable effort to inform me of what my total cost of care may be. **An active credit card will be required & kept on file for billing**. LTS will send claims to insurance & upon their determination of benefits, I will be notified of patient responsibility. LTS may use my card to bill for any balance without additional authorization. *Circumstances when my card may be charged include but are not limited to* missed or canceled appointments without 24-hour notice; unpaid copays, deductibles or co-insurance, non-covered services or denial of services for which you have received an ABN (if traditional Medicare is your primary insurance) or for which we are out of network; any amount not paid by your insurance 60 days after a corrected claim has been filed. This will not compromise your ability to question your insurance company's determination of payment or ability to dispute a charge. Any balance unable to be charged will be sent to collections. **MEDICARE**: *If I am a Medicare patient, then I (the Medicare beneficiary) request payment of authorized benefits for services provided by LTS be made to LTS. This authorization applies to all occasions of services until it is revoked (in writing) by me. I am aware that according to CMS Manual Pub 100-02 (transmittal 88), a plan of care must be signed by my physician within 30 days for payment of services. If a plan of care is not signed, I will be liable for the cost of services rendered unless or until my physician signs my plan of care. The 2022 deductible is $233. I have a 20% co-pay (if I have no supplemental insurance). The annual 2022 cap for Occupational Therapy services is $2,150. An Advanced Beneficiary Notice is required to be signed by me for any anticipated non-covered service.*
Acknowledgement to Pay for Non-Covered Services
______ I understand LTS will bill my insurance company for services rendered. I agree to pay my deductible &/or co-payments at the time of each appointment. I understand that I am responsible for my deductible, co-pays & any amount not covered by my insurance (including services or medical supplies my insurance company denies or deems as "non-covered"). **MEDICARE**: *Medicare will pay for <u>medical equipment & supplies*</u> only if a supplier has a Medicare supplier number (when those items are coverable & meet Medicare requirements). We do not have a Medicare supplier number. Medicare will not pay for any medical equipment & supplies (DME) we sell to you. You will be personally & fully responsible for payment if you choose to obtain DME from us.* **HOME HEALTH: I cannot receive home health service & also receive service from LTS.** I <u>am not</u> currently receiving any home health service (i.e. no one is coming to check my blood pressure, help with bathing, provide therapy, etc.). I will notify LTS if I plan to begin home health service while I am receiving care from them. **If I fail to notify LTS <u>before</u> home health begins, I agree to pay for all service provided by LTS** after home health begins, & I request LTS stop billing Medicare (& any other insurance) so they can bill me privately for their services. I agree to pay for all collection or legal fees incurred by LTS to recoup payment (whether it was service denied by Medicare or whether it was service for which I have not paid).
Late-Show / No-Show / Returned Checks Policy
______For **office visits**, I understand that if I am more than 10 minutes late for my appointment, I may be asked to reschedule. For **home visits**, I understand all visit times are an estimate. A therapist will attempt to notify me when on their way & may not come if I do not respond within (5) minutes. For **all visits**, *I will be charged a $25 fee for no-shows or appointments canceled less than (1) business day in advance*. I understand that any returned checks will be assessed a $33 fee (plus the amount due). If I pay an invoice online & later dispute the payment, a charge back fee of $15 will be passed on to me. If I pay with a bank transfer & have insufficient funds, a charge back fee of $5 will be assessed to me (plus the amount due). Such fees will be due at the time of my next appointment or immediately upon notification.
Supplies
______ Lymphedema treatment usually involves multi-layer bandaging with reusable supplies. Two sets are needed. If I do not purchase my own, I may be asked to provide a refundable deposit to cover any supplies provided to me on loan for therapy. These supplies must be returned to the LTS office in the same condition with which they were given to me on the last day of therapy. Any supplies damaged or not returned will be deducted from my deposit. If I am not asked to provide a deposit for loaned supplies, or if I choose to obtain new supplies, I will be responsible for purchasing all lymphedema supplies needed for treatment. These can be obtained from the office or online (a list can be provided).
Transaction
______A 2018 federal court ruling has granted permission to pass credit card transaction fees on to the card holder. The Texas State Attorney General's office declared any credit card transaction processing fee may be passed on to the customer. We use two merchants: Square (they charge 3.5%+$0.15 for each keyed transaction) & Wave (if paying an invoice online; they charge 2.9%+$0.60 per credit card transaction; 1% for bank transactions). The merchant's fee will be passed on to you at the time of service or in a subsequent invoice. You can save this fee by paying with cash, check or using Zelle. Therapy Notes uses Stripe which charges 2.70% plus $0.10 per transaction. Visit client portal at: <u>https://www.therapyportal.com/p/lymphedema75068/</u>.

I certify that I am 18 years of age &/or the legal guardian/guarantor/power of attorney. I have read, understand & accept full financial responsibility for the patient listed below.

Patient Name: ______________________________ Legal Guardian/ Power of Attorney: ______________ (attach proof)

Signature: ______________________________ Date: ______________________________

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Refund/Return Policy:

Custom Garments, Other Compression & Equipment

There are no refunds on custom garments as they are made specifically for you. However, the following modifications can be made:

- up to two modifications can be provided at no additional cost (including shipping return) within 30 days of receiving item when the change requested is due to fitter error (i.e. the garment doesn't fit appropriately).
- up to one modification can be provided at no cost (excluding shipping) within 30 days of receiving item when the change requested is not due to fitter error (i.e. patient preference).

Customer is responsible for washing & returning garments to 309 W. Eldorado Pkwy, #108, Little Elm, Tx 75068 before revision(s) will be ordered. Patient is not permitted to continue wearing a garment while awaiting a revised garment.

Non-Custom Compression & Equipment

Other compression (i.e. non-custom compression) may be able to be returned depending on the manufacturer's policy **which is usually 30 days (except shipping)**. This requires:

- items to be in new & unused condition & in original packaging (in some cases, the manufacturer may allow a return if a garment has been worn once, but it must be laundered & in new condition with original packaging).
- return must be requested & returned to the LTS office within 7 days of receiving item.

Customer is responsible for returning compression & equipment to 309 W. Eldorado Pkwy #108, Little Elm, Tx 75068 in the above condition(s) before a refund is issued. Shipping costs & manufacturer restocking fees will be deducted from refund amount.

Note: Medicare does not pay for lymphedema supplies or compression. We are not a Medicare DME provider.

I have read this return policy & am in agreement with the terms:

____
Patient Name Date

____
Signature

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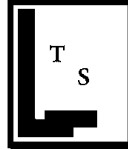

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GENERAL PHOTOGRAPH/VIDEO RELEASE FORM

Your swelling condition, related treatment & story may be helpful to someone else. Knowledge of lymphedema (or swelling conditions that are not lymphedema) is lacking in the local, national & international arena. LTS would like to use your image, audio &/or video to increase awareness of swelling conditions.

I hereby give my consent for LTS, its subsidiaries, licensees, successors & assignees (the "Company"), the right to use, publish & reproduce pictures of me in electronic (video) form, & sound & video recordings of my voice, depicting before, during, & after treatment for the purpose of being shared with prospective patients, in courses or books for education or training, or via the Internet within medical education settings. It is my responsibility to remove or conceal any unique body marks or other identifying information that could result in my personal identification. I also agree to the use of my photographs &/ or video for general advertising & promotional purposes in any & all media including but not limited to print media, television, the Internet (including the Website), social media, brochures & educational seminars. This permission extends to all languages, media, formats, markets & geographies now or later. I understand & agree that these images may be used for an indefinite period of time by the Company. I also understand that **facial features & first names only will be used unless I request otherwise**. I can request otherwise by initialing below.

_____ I want my facial features blurred ______ I do not want my first name used.

A description of my medical history may be included in commentary for the purpose of explaining my swelling. I understand that this information & images may be edited, copied, exhibited, published or distributed, & I waive the right to inspect or approve the finished product in its obscured form. *I, however, reserve the right to contact the Company in writing to request removal of any image, audio or video that makes me uncomfortable. Request must be sent via certified mail with signature confirmation of delivery. Such image or video will be removed within 30 days after receipt.* I waive any right to royalties or other compensation arising or related to the use of my image or recording.

The undersigned releases the Company from all claims for libel, slander, invasion of privacy, infringement of copyright or right of publicity, or any other claim related to the voice recordings or images. This release includes without limitation any claims related to blurring, distortion, modifications, or other means of alteration whether intentional or otherwise (or use of a fictitious name) that may occur or be produced in the processing or publication of the voice &/or image.

I understand I may refuse to sign this form & that is voluntary. If I do, an interview will not take place. By signing this form, I acknowledge that I have completely read & fully understand the above release & agree to be bound thereby.

Patient Name: ____________________ Guardian/POA: (proof attached) ____________________

Signature: ____________________ Date: ____________________

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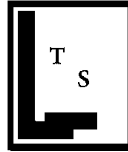

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Past Medical History and Swelling

Briefly describe your past medical history (surgeries & medical diagnoses):

Provide a date of when your swelling began:

What activities are difficult for you because of your swelling?

What is your pain level (0-10 with 0 being none & 10 being terrible)?

What is important to you to gain from receiving therapy for lymphedema?