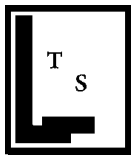
Rebecca Summers, OT, CLT-LANA, CSR
Licensed Occupational Therapist
Certified Lymphedema Therapist
Lymphology Association of North America-certified



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

A resource for physicians & patients

Private Pay			
Name: **Sex:**		**Date of Birth:**	
Home Address:		**Phone:**	
		Email:	
Emergency Contact & Relationship:		**Physician:**	
Phone:		**Phone / Fax:**	
		NPI:	

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 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

_____ I understand resuscitation will be attempted in the event of a life threatening situation unless I have a DNR form on file with LTS. If I do have such form, I will provide a copy to LTS prior to my first session.

Consent to Treatment & Photographs

_____ I consent to medical treatment by Lymphedema Therapy Source, PLLC for the diagnosis & treatment of a physical condition I may have.

Supplies

_____ I am responsible for having all supplies cleaned, air dried, and 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.

Acknowledgement of Privacy Notice

_____ Lymphedema Therapy Source, PLLC 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 Lymphedema Therapy Source, PLLC 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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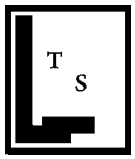

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FINANCIALS

Private Pay
_____ In accordance with HIPPA regulations as outlined in the Federal Register, Volume 78, No. 17, page 5628, I am choosing of my own free will to NOT authorize the release of any medical or other information necessary to process claims. I am instead choosing of my own free will to pay cash out of my own pocket for all services, supplies &/or compression provided to me by Lymphedema Therapy Source, PLLC. This agreement shall remain in full force & effect for one year following the termination of services. This authorization applies to all occasions of services or products until it is revoked in writing. I agree to pay the balance at the time of each appointment (***or via emailed invoice prior to the evaluation).*** 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 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; any unpaid balance due prior to your next session including your discharge visit. This will not compromise your ability to dispute a charge. Any balance unable to be charged will be sent to collections.
Late-Show Policy, No-Show Policy & Returned Checks
_____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 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 may 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
_____ 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) and Wave (if paying an invoice online; they charge 2.9%+$0.60 per credit card transaction; 1% for bank transactions). The merchant's fee may be passed on to you at the time of service or in a subsequent invoice. You can save this fee by paying with cash or check. You can also use Zelle. Therapy Notes uses Stripe which charges 2.70% plus $0.10 per transaction. Visit client portal at: https://www.therapyportal.com/p/lymphedema75068/.

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: _____ Guardian/POA: _____ (attach proof)

Signature: _____ Date: _____

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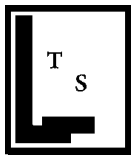

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Refund/Return Policy:

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 Lymphedema Therapy Source 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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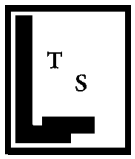

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GENERAL PHOTOGRAPH/VIDEO RELEASE FORM

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

I hereby give my consent for Lymphedema Therapy Source, PLLC, its subsidiaries, licensees, successors and assignees (the "Company"), the right to use, publish and reproduce pictures of me in electronic (video) form, and sound and video recordings of my voice, depicting before, during, and 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 and/ or video for general advertising and promotional purposes in any and all media including but not limited to print media, television, the Internet (including the Website), social media, brochures and educational seminars. This permission extends to all languages, media, formats, markets and geographies now or later. I understand and agree that these images may be used for an indefinite period of time by the Company. I also understand that **facial features and 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 or last 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 and images may be edited, copied, exhibited, published or distributed, and 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 and/or image.

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

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

Signature: _____ Date: _____

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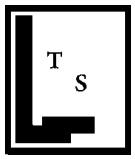

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Briefly describe your past medical history (surgeries and medical diagnoses):

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?