Lymphatic Therapy, Inc.

Expert Care for Lymphedema & Chronic Swelling

6841 South Eastern Ave Suite # 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, 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 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 claim is made for coverage.**

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 insurance carrier.**

______________________________________ ______________________________

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. 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 individual. We strive for a successful outcome in every treatment, that is our goal at Lymphatic Therapy, Inc. and we all work together as a team to make that a reality to you.

Patient Name: ______________________________ **Date:** ____________________

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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.

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Signature of Responsible Person **Date**