H.O.P.E Life
Lymphedema & Rehab Center

Patient Information Form

Last Name: _____ **First Name:** _____ **M.I.:** _____

Date of Birth: _____ **Social Security Number:** _____

Gender: _____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone Number: _____

Alternative Phone Number: _____

Email Address: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Emergency Contact: _____ **Contact Number:** _____

Employer: _____ **Phone Number:** _____

What problem(s) brought you to H.O.P.E Life Lymphedema & Rehab Center today?

_____

Are you CURRENTLY receiving Home Health of ANY type? YES or NO (Circle One)

Who referred you to us? _____

When was your last visit with your referring physician? _____

Please provide a list of medications with your paperwork.

- I authorize release of information requested by my insurance plan for payment.
- I understand that I am financially responsible for any balance due.
- I agree to comply with the terms and conditions outlines on this form.
- I herby acknowledge that I have received a copy of the Notice of Privacy Practices.
- (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ **Date:** _____

Medical Questionnaire

Name: _____
DOB: _____
Referring Physician: _____
Primary Care Physician: _____

What problem/diagnosis brings you here today? _____
Side of Injury: (circle one) **L / R** Date of Injury? _____
Pain Level At Worst: (circle One) **1 2 3 4 5 6 7 8 9 10**
Pain Level At Best: (circle One) **1 2 3 4 5 6 7 8 9 10**
Pain Level Currently: (circle One) **1 2 3 4 5 6 7 8 9 10**
What eases your symptoms? _____
What aggravates your symptoms? _____
Is your pain worse in the: (circle one) **AM PM MIDDAY**
Have you had this/similar condition before? **YES NO**
Have you had any tests or treatments for this recently? **YES NO**
If yes, please list: _____
Current Level of Physical Activity: **Low Medium High**
What goals do you hope to accomplish with Physical Therapy?

_____
Why? _____

Medical History

- ☐ Asthma
- ☐ Arthritis
- ☐ Blackouts
- ☐ Blood Clot
- ☐ Incontinence
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Current Infections
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Immunosuppressant
- ☐ Migraine Headaches
- ☐ Major Spinal Injury
- ☐ MRSA
- ☐ Muscle Tears
- ☐ Osteoporosis
- ☐ Pacemaker/Defibrillator
- ☐ Parkinson's
- ☐ Seizures
- ☐ Spinal Injury
- ☐ Stoke
- ☐ Stains/Sprains
- ☐ Traumatic Injury

If you have swelling:
Location of Swelling: _____ When did it begin? _____
Does your swelling go down at night? **YES / NO** (Circle One)
What makes your swelling worse? _____
What makes your swelling better? _____
Have you had previous treatment for swelling? **YES / NO** (Circle One)
If so, when and where? _____
Do you use, or have you used any of the following to manage your swelling? (Check all that apply)

- ☐ Compression Garments
- ☐ Compression Pump
- ☐ Bandaging
- ☐ Diuretics (water pills)
- ☐ Elevation/Exercise
- ☐ Self Massage
- ☐ Other (please list):
  _____
  _____

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Patient Consent for Medical Photography

Print Name _____ Date _____

I hereby grant H.O.P.E. Life and Rehabilitation permission to take pictures and use medical photographs of me or my child (or person I am legal guardian). I understand that my photographs may be used in my medical record, for purposed of medical teaching and training, for the publication of medical journals or cases studies.

By signing this form, I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to other medical professionals, medical researchers, and students who regularly use publications for research and education. Although these photographs will be used without any identifying information, such as name, I understand that it is possible that someone may recognize me. I also agree that my image may be shown for teaching purposes and be used for my medical record to show treatment progression, or lack of.

By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to these medical photographs *WILL* in *NO* way affect the medical care you receive

I hereby acknowledge that I am 21 years or older and am of sound mind to sign my name below. I have read the release before signing my name below and fully understand its content, meaning, and the impact of this contract.

Signature _____ Date _____

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Home Health Verification

Are you currently receiving Home Health services of ANY TYPE?

YES or NO

(Circle One)

If yes, please specify:

_____

_____

Be advised that if you are currently receiving Home Health Care Services, the services provided at our facility may not be covered by your insurance resulting in out of pocket expenses. If you are currently under the care of Home Health and still want the care of H.O.P.E. Life Lymphedema and Rehab Center, by signing below, you agree to any associated costs with services rendered at this facility.

_____

Patient Signature Date

_____

Patient Name - Printed

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Lymphedema & Rehab Center

Cancellation & No Show Policy

We understand that situations arise in which you must cancel your appointment. But in an effort to utilized our patient waiting list and limited appointment availability, we kindly request that provide 24 hour notice. This will enable us to schedule another person in that appointment slot.

When cancellations occur in less than 24 hours, we are unable to offer that appointment slot to other patients.

If you do not show for any 3 visits with less than 24 hour notice, we will require a sit down re-evaluation of continued treatment and will be contacting the referring physician in regards to a new plan of care. At this time, a new referral may be required to be sent by the referring physician. By signing this, you the patient understand and agree to the terms of this policy.

Patient Signature Date

Patient Name - Printed

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority