Metamora
Physical Therapy

Date _____

Name: (First)_____ (Last)_____ (Middle) _____ Birth Date_____

Address: _____ Apt #/PO Box # _____

City _____ State _____ Zip_____

Day Phone _____ Home Phone _____ Cell Phone_____

*If you **do not** want to receive appointment reminders, please check ☐

E-Mail _____
(For appointment reminders, updates, seminars, event notices)

Marital Status: ___Married ___Single ___Other Sex: ___Male ___Female

Former Patient: ___Yes ___No

How did you hear of Metamora Physical Therapy? _____

Are you currently receiving any home care services? (PT, OT, Nursing, Speech) ___Yes ___No

Have you had home care services this year? (PT, OT, Speech) ___Yes ___No

Referring Physician:_____

If you would like us to send copies of correspondence to your primary care physician, please complete:

Primary Care Physician: _____ Phone:_____

PATIENT INFORMATION

Current employment/school information: _____

AUTO

Is this an Auto Accident? ___Yes ___No If yes, please complete the following:

Date of accident:_____ In what city and state did the accident occur?: _____

Is this a Lawsuit? ___Yes ___No Law firm name: _____

Attorney Name: _____ Attorney Phone: _____

WORKER'S COMPENSATION

Is this a worker's compensation claim? ___Yes ___No If yes, please complete the following:

Employers Name: _____ Employers Phone#: _____

City/State:_____ Job Title:_____

Is this an approved Worker's Comp Injury? ___Yes ___No

Date of Injury: _____ In what city and state did the injury occur? _____

Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____

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Patient Name:_____ Date:_____

Please list any medications, vitamins, or supplements you are currently taking:

Medication	Dosage	Frequency

Please list any allergies you have:

KLC - Brief Medical History

(to be completed by patient on intake)

Date: _____

Name: _____ DOB: _____

Completed by: ☐ Patient (listed above) ☐ Other: _____

Do you currently experience swelling/lymphedema? (Please circle all that apply)

right arm left arm both arms breast right leg left leg both legs genital head & neck

Other, please explain: _____

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: _____

_____

_____

Have you had any surgery? ☐ Yes ☐ No

If yes, list surgeries and dates: _____

_____

_____

Have you had any lymph nodes removed? ☐ Yes ☐ No

If yes, how many: _____

Have you ever received radiation therapy for cancer? ☐ Yes ☐ No

If yes, list area of radiation and dates here: _____

_____

_____

Have you had chemotherapy? ☐ Yes ☐ No

If yes, how long ago? _____

Have you had any infections (cellulitis)? ☐ Yes ☐ No

If yes, how long ago was the last one? _____

Is there a family history of lymphedema? ☐ Yes ☐ No

If yes, please explain: _____

Do you have pain? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have any loss of function or mobility? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have any difficulties with any of the following?

☐ Walking	☐ Reaching feet and toes	☐ Preparing meals
☐ Dressing	☐ Bathing/showering	☐ Other

If other, please explain: _____

_____

What is your current living situation?

☐ Private home/apartment (alone)	☐ Nursing home	☐ Hospice
☐ Home with spouse or companion	☐ Assisted living	☐ Other

If other, please explain: _____

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

☐ Asthma	☐ Hyperthyroidism	☐ Crohn's Disease
☐ Bronchitis	☐ Kidney failure	☐ Diverticulitis
☐ Difficulties breathing	☐ Diabetes	☐ Recent abdominal surgery
☐ Irregular heart beat	☐ Infections (cellulitis)	☐ Unexplained pain
☐ Heart edema	☐ Sleep apnea	☐ Deep venous thrombosis (blood clot)
☐ Hypertension	☐ Malignancy (cancer)	☐ Latex allergy
☐	☐	☐

Do you have any other medical problems not listed above? ☐ Yes ☐ No

If yes, please explain: _____

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other

If other, please explain: _____

Are you taking any medication? ☐ Yes ☐ No

If yes, list medications and amounts here: _____

_____

At the time you are completing this, are you pregnant or is there a chance you could be pregnant?

☐ Yes ☐ No

PREVIOUS TREATMENTS

Have you had previous treatment for swelling/lymphedema? ☐ Yes ☐ No

If yes, check ALL that apply:

☐ Manual Lymph Drainage (MLD)	☐ Compression pump	☐ Compression garments
☐ Compression bandaging	☐ Flexitouch	☐
☐ Lymphedema exercise	☐ Low level laser	☐

If yes, please explain your experience, success, or lack of success:

_____

_____

_____

_____

Do you currently wear a compression sleeve or stocking? ☐ Yes ☐ No

If yes, how often do you wear it and how old is it?:_____

_____

Do you currently use compression at night? ☐ Yes ☐ No

If yes, please explain: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you familiar with the National Lymphedema Network? ☐ Yes ☐ No

Are you familiar with the precautions (risk-reduction practices) for Lymphedema? ☐ Yes ☐ No

Are you a member of a breast cancer or lymphedema support group? ☐ Yes ☐ No

If yes, please describe: _____

What is the reason that you are seeking help? _____

_____

What are your treatment goals? _____

_____

_____

Is there anything else you would like to tell us at this time? _____

_____

_____

LLIS - Initial Visit

Today's Date: ____/____/____ Date of Birth: ____/____/____

Name: _____

Eval: _____ 10th visit: _____ 20th visit: _____ 30th visit: _____ D/C: _____

Please rate your pain level with activity:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — VERY SEVERE PAIN

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 best describes your symptom level.

I. Physical Concerns

(NOTE: If swelling and symptoms are the same in both limbs, rate them the same; rate only the worst limb)

1. The amount of pain associated with my lymphedema is:	0	1	2	3	4	
	no pain				severe pain	
2. The amount of limb heaviness associated with my lymphedema is:	0	1	2	3	4	
	no heaviness				extremely heavy	
3. The amount of skin tightness associated with my lymphedema is:	0	1	2	3	4	
	no tightness				extremely tight	
4. The size of my swollen limb(s) seems:	0	1	2	3	4	
	normal size				extremely large	

5. Lymphedema affects the movement of my swollen limb(s):

0 1 2 3 4

normal movement — extremely limited

6. The strength in my swollen limb(s) is:

0 1 2 3 4

normal strength — extremely weak

II. Psychosocial Concerns

7. Lymphedema affects my body image (how I think I look):

0 1 2 3 4

not at all — completely

8. Lymphedema affects my socializing with others.

0 1 2 3 4

no interference — interferes completely

9. Lymphedema affects my intimate relations with spouse or partner (rate 0 if not applicable).

0 1 2 3 4

no interference — interferes completely

10. Lymphedema "gets me down" (i.e., I have feelings of depression, frustration, or anger due to the lymphedema).

0 1 2 3 4

never — constantly

11. I must rely on others for help due to my lymphedema.

0 1 2 3 4

not at all — completely

12. I know what to do to manage my lymphedema.

0 1 2 3 4

good understanding — no understanding

III. Functional Concerns

13. Lymphedema affects my ability to perform self-care activities (i.e., eating, dressing, hygiene).

0 1 2 3 4

no interference — interferes completely

14. Lymphedema affects my ability to perform routine home or work-related activities.

0 1 2 3 4

no interference — interferes completely

15. Lymphedema affects my performance of preferred leisure activities.

0 1 2 3 4

no interference — interferes completely

16. Lymphedema affects the proper fit of clothing/shoes.

0 1 2 3 4

fits normally — unable to wear

17. Lymphedema affects my sleep.

0 1 2 3 4

no interference — 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+

Metamora
Physical Therapy

Letter of Understanding/Agreement/Patient Contract

This Contract serves as a letter of understanding about the treatment of lymphedema which you are about to receive.

Patient Name: _____
print

_____ initials I have been informed that the treatment of lymphedema – which consists of Manual Lymph Drainage (MLD), compression bandaging, and instructions in exercise and self-care – requires daily appointments (Monday-Friday) before the treatment sequence tapers to 2-3 appointments/week, until my custom garment(s) arrive.

_____ After my treatments with the physical/occupational therapists, I'll be required - to the best of my abilities - to perform a self-care protocol which consists of daily wear of daytime and nighttime garments and any other recommendations taught during my therapy visits.

_____ Treatment charges will be submitted to my insurance company. I understand that I am responsible for applicable deductibles and copays.

_____ I understand that the estimated total number of treatments is: _____

The **estimated retail cost** of my compression garment(s) is below. How much I will ultimately pay will depend on whether my insurance covers compression garments and if it does, whether I will owe a deductible and/or a copay.

My therapist will contact a durable medical equipment (DME) dealer to determine my insurance coverage. If my insurance provider does not cover compression garments, my therapist will provide me with instructions on how to order my garment(s) online so that I can pay directly. If needed, my therapist will provide me with measurements for a custom garment. For returns, I will need to refer to the policy of the provider of the compression garment.

Compression bandaging supplies	$_____
Compression garment(s)	$_____
Night compression garment(s)	$_____
Total estimated retail cost	$_____

I understand that the above total is only an estimate of the cost of compression garment(s) I need for successful treatment. Additional costs may be incurred during the course of my treatment. These additional costs will be discussed with me with as much advance notice as possible.

I have read and understand this estimation of proposed treatment visits, costs, and payment policy.

_____ Date: _____
Patient Signature

Metamora
Physical Therapy

APPOINTMENT ATTENDANCE AGREEMENT

I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks.

I agree to and understand the following:

1. I must provide at least a 24-hour notice when I need to cancel or reschedule an appointment. I understand that a cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50.00.
2. I understand that three (3) cancelled appointments in a row, regardless of given notice, will result in an automatic discharge from physical therapy.
3. I agree to provide a credit card to remain on file for cancellation/no show charges. **I understand my card will be charged automatically if I no-show an appointment.** (We understand that cancellations will occur due to sickness, scheduling conflicts, emergencies, etc. We will consider appropriate allowances in these circumstances.)

Printed name: _____

Signature: _____

Date: _____

Metamora Physical Therapy

3562 S. Lapeer Rd. Ste F, Metamora, MI 48455 Phone: 810-212-1277 Fax: 810-212-1282

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least a 24-hour notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50.

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Metamora PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Metamora PT with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. When you provide a check as payment in the clinic, you authorize us to use the information from your check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day and you will not receive your check back from your financial institution.
Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Metamora PT all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Metamora PT may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Metamora PT's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Metamora PT's Notice of Privacy Practices

and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. HIPAA CONSENTS: In compliance with HIPAA regulations, I give consent to the following individuals to receive verbal information regarding the billing and scheduling of my account:

Name/Relationship_____

Name/Relationship _____

Name/Relationship_____

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

7. CONSENT FOR EMERGENCY CONTACT INFORMATION:

Person to contact in case of an emergency:

Name:_____

Telephone Number:_____ Relationship:_____

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient/Legally Responsible Person:_____

Printed Name of above:_____ Date: _____

Metamora Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Metamora Physical Therapy, LLC
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Metamora Physical Therapy, LLC's LEGAL DUTY

Metamora Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Metamora Physical Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Metamora Physical Therapy, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Metamora Physical Therapy, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Metamora Physical Therapy, LLC 's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Metamora Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Metamora Physical Therapy, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Metamora Physical Therapy, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Metamora Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Metamora Physical Therapy, LLC
Office Administrator
3562 S. Lapeer Rd. Ste F, Metamora, MI 48455
Telephone: 810-212-1277 Fax: 810-212-1282

Metamora Physical Therapy, LLC
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Metamora Physical Therapy, LLC's Notice of Information Practices. I understand that Metamora Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in Metamora Physical Therapy, LLC's Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

Your Lymphedema Treatment

To Do Before the First Day of Treatment

As soon as possible, order the compression bandages recommended by your therapist. **You will need these bandages for the first day of treatment.** Refer to the ordering instructions/form provided by your therapist. Please bring all of the ordered supplies with you to your first treatment.

What to Wear

For arm treatment: A Loose-fitting shirt, preferably short sleeve
For leg treatment: Loose fitting pants/shorts/skirt plus a large shoe that can accommodate the bulk of the bandage, or a cast shoe, as recommended by your therapist

First Treatment

The therapist will treat you with manual lymph drainage (MLD) massage, cut foam sheets to fit your arm or leg, and then wrap your limb with layers of the foam and compression wraps/bandages. You may also be introduced to exercises to perform with your bandages on.

Your Assignment

To ensure the effectiveness of your treatment, your goal is to wear your compression bandages for 22-24 hours between treatments. You can remove your bandages to shower approximately two hours prior to your next appointment. Please **roll your bandages** for re-application and bring all supplies with you to the next appointment.

If the bandages cause any pain, rubbing, throbbing, discoloration, numbness, or tingling, remove them immediately. Note the area(s) of discomfort and report all details to your therapist during your next treatment session.

Course of Treatment

- You will receive treatment 5 days/week for two weeks, then 3 days/week for one to two weeks. However, this protocol may differ per therapist recommendation and your specific presentation of swelling. Typically, your treatment sessions will include one or more of the following: MLD, application of bandages, instructions on skin care, and/or instructions on self-care.
- At the end of the second week, if your swelling has been reduced sufficiently, your therapist will measure your affected area for compression *garments*, and, depending on your insurance coverage, either order your garment(s) for you, or give you instructions on how to order the garment(s) yourself.
- Your garment(s) should arrive within 1-2 weeks from the day they are ordered.
- Once your garment(s) have arrived, your therapist will teach you how to put them on, take them off, and care for them.
- After your last treatment, we recommend a follow-up evaluation in 6 months or when directed by your therapist.

It is a privilege to partner with you and provide your lymphedema care.

Please call or email your therapist with questions or concerns at 810-212-1277 *or* contactus@metamorapt.com

Healthy Habits for Patients at Risk for Lymphedema

Healthy Lifestyle:

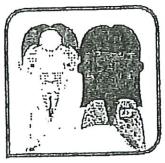
A healthy diet and exercise are important for overall good health.

- Maintain optimal weight through a healthy diet and exercise to significantly lower risk of lymphedema.
- Gradually build up the duration and intensity of any activity or exercise. Review the Exercise Position Paper.*
- Take frequent rest periods during activity to allow for recovery.
- Monitor the at-risk area during and after activity for change in size, shape, tissue, texture, soreness, heaviness, or firmness.

Skin Care:

Make sure that your skin is in good condition.

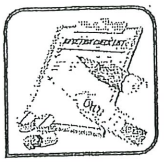
- Keep your at-risk body part clean and dry.
- Apply moisturizer daily to prevent chapping/chafing of skin.
- Pay attention to nail care and do not cut cuticles.
- Protect exposed skin with sunscreen and insect repellent.
- Use care with razors to avoid nicks and skin irritation.



Medical Check-ups:

*Find a certified lymphedema therapist (CLT).**

- Review your individual situation, get screened for lymphedema, and discuss risk factors with your CLT.
- Ask your CLT or healthcare professional if compression garments for air travel and strenuous activity are appropriate for you.
- If a compression garment is recommended, make sure it is properly fitted and you understand the wear, care, and replacement guidelines.
- Set a follow-up schedule based on your needs with your CLT.
- Report any changes in your at-risk body part to your CLT.

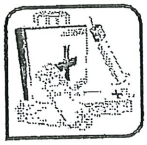


Infection Education:

Know the signs of infection and what to do if you suspect you have one.

- Signs of infection: rash, itching, redness, pain, increased skin temperature, increased swelling, fever, or flu-like symptoms.
- If any of these symptoms occur, contact your healtcare professional immediately for early treatment of possible infection.
- If a scratch or puncture to your skin occurs, wash it with soap and water, apply topical antibiotics, and observe for signs of infection.
- Keep a small first aid kit with you when traveling.

TRY TO AVOID POSSIBLE TRIGGERS

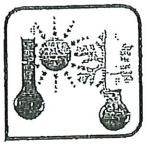


Injury or Trauma

- Wear gloves while doing activities that may cause skin injury (eg, washing dishes, gardening, using chemicals like detergent).
- Try to avoid punctures (eg, injections and blood draws).

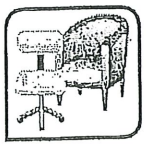
Limb Constriction

- Wear loose jewelry and clothing.
- Avoid carrying a heavy bag or purse over the at-risk limb.
- Try to avoid blood pressure cuffs on the at-risk limb.



Extreme Temperatures

- Avoid exposure to extreme cold, which can cause rebound swelling or chapping of skin.
- Avoid prolonged (> 15 min.) exposure to heat, particularly hot tubs and saunas.



Prolonged Inactivity

At-risk for leg lymphedema?

- Avoid prolonged standing or sitting by moving and changing position throughout the day.
- Wear properly, fitted footwear and hosiery.

Please Note: These guidelines are meant to help reduce your risk of developing lymphedema and are NOT prevention guidelines. Because there is little research about risk reduction, many of these use a common-sense approach based on the body's anatomy and knowledge gained from decades of clinical experience by experts in the field. Risk reduction should always be individualized by a certified lymphedema therapist and healthcare professional.

For a full list of the NLN's risk reduction practices, please see our website: www.lymphnet.org/riskreduction

*To review the NLN's other position papers and find a CLT in your area: www.lymphnet.org

National Lymphedema Network