



● OUTPATIENT AGREEMENT ●

We will provide Complex Decongestive Therapy (CDT) tailored to your individual needs. Including but not limited to:

- Bandaging
- Manual Lymphatic Drainage (MLD)
- Remedial Therapeutic Exercises
- Possible Pump Referral
- Recommendations of Appropriate Garments
- Educate Patient and Caregivers on Lymphedema Disease Process and Treatments
- Ensure Independence with Lymphedema Home Exercise Program

TREATMENT TIME

The length of treatment will vary based on your individual needs. Typical treatment duration can be **2-3 times a week for 3-8 weeks**, depending on severity of the condition.

An example of treatment:

3 times a week starting: Monday, Wednesday, Friday - attend therapy for skin care, MLD, and bandaging. This will continue until your edema is maximally decreased - typically 2-4 weeks. At that point you will be measured for a garment. Your frequency will decrease to 1-2 visits a week for the next 2-3 weeks. At this point, expect 1-2 more visits over a couple of months to ensure independence with your lymphedema program. Some of these can be virtual visits you can do from home.

You and your practitioner will determine the most appropriate schedule.

Information and ITEMS NEEDED BEFORE EVALUATION APPOINTMENT

- Your physician needs to **FAX** the following information to **Lymphwell at (888) 701-5165**:
 - **Prescription Stating:**
Physical therapy to evaluate and treat for (bilateral LE lymphedema)
 - **Demographics:**
All Patient Information - Name, Address, Phone Number, Email Address, Date of Birth, Insurance Information (Primary/Secondary)
- You need to complete the **Patient Intake** and **Outcome Forms** prior to your evaluation. These will be provided to you via email. If you cannot email, you may request to complete them in the office. Some clinic locations do not have this option. Please ask your intake specialist for details on how to fill them out over the phone if this applies to you.
- There will be a \$50.00 charge for missed evaluation appointments.** By signing this form you agree to those charges. You have until 5pm the business day prior to your evaluation to cancel without penalty.



INSURANCE AND FEES

- ****As a courtesy, we will reach out to your insurance company and provide you with a cost estimate prior to your evaluation. We strongly encourage you to reach out to your insurance company to verify your coverage in our clinic. This is only an estimate, and Lymphwell is not responsible for any misquoting by your insurance representative. ****

If you have insurance, we will submit our visit fees to your insurance company.

The following insurance companies are accepted:

In Network: Blue Cross Blue Shield, Medicare, Medicaid

Out of Network: Aetna, Cigna, Humana, WellMed, United Healthcare

If you do not see your insurance listed, we will happily check your policy to see if out of network benefits are offered.

- **Home Health and Private Pay**

If you are enrolled in home health, **insurance will not cover out-patient expenses**. If you choose to stay on home health, you can elect for **private pay**.

- **Supply Billing**

Should you choose to purchase any supplies through our office you will be fully responsible for those purchases. If you elect to seek reimbursement through your insurance company for any items your policy will cover, we will happily provide you any documentation we have available to accommodate that claim. We cannot guarantee their payment or reimbursement.

If you are private pay, the **initial evaluation rate** is \$200.00 for 30 minutes to 1 hour. During your first appointment assessments, measurements and pictures will be taken.

The **regular treatment rate** for each ongoing session is \$150.00. Regular treatment sessions could include skin care, wound care, bandaging or Manual Lymphatic Drainage (MLD) which could take approximately 30 minutes to 1 hour.

ITEMS NEEDED BEFORE TREATMENT CAN BEGIN

- **Bandages & Supply Fees:**
 - \$150 - 300 for bilateral lower extremities
 - \$150 - 200 for one upper extremity
- **Wound Care Supplies**
 - **Fees Vary**
- **Recommended Shoe Gear**
 - 1 ½ -2 sizes bigger tennis shoe, crocs, Velcro adjusted Teva, or slides
- **Recommended Clothing**
 - Wide leg pants, shorts, or skirts

****Patients may purchase any therapy supplies on their own, but supplies must be purchased and then approved by our office before treatment can begin. Patients may request a shopping list from the Front Desk and PT Assistants, as an estimate of quantity and brands needed. *****



PAYMENT DUE DATE

Payment is due at the time of treatment. Cash, checks, and credit cards are accepted. A \$45.00 late fee will be billed for late payment. Cancelled checks will result in a \$35 charge. Should you have any outstanding balance left unpaid after 90 days, you will be billed a collection fee of 35% of your total amount due for visits and or supplies purchased before sending your account to a collection agency. For all card transactions there is a 3% fee added to the total.

CANCELLATIONS

We require at least a 24-hour's notice to cancel your appointment. **If you cancel on the same day or don't show up to your appointment, you will be charged \$35.00. If you are running late, please call our office immediately. If you are more than 15 minutes late, you will be charged a no-show fee, and will not be seen until your next scheduled appointment. Recurring absences, and no shows may result in you being removed from our schedule entirely.**

BILLING POLICY, RELEASE AND AUTHORIZATION

I authorize Lymphwell to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Lymphwell. I authorize Lymphwell to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical photographs to be made of me or person for whom I am legal guardian. I understand that the information may be used in my medical records, for purposes of sharing with my physician, and for the purposes of medical teaching, or for publication in medical textbooks, journals, or electronic publications. This also includes use on Lymphwell's website and company communication documents. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in the professional education. Your photographs will be used WITHOUT identifying information such as your name. By consenting to these medical photographs, I understand I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact Lymphwell by email at lindy.ditmore@lymphwell.com.

CONSENT FOR PHI/ePHI VIA TEXT MESSAGE/INTERNET/EMAIL

I consent to transmit my Protected Health Information ("PHI") and Electronic Protected Health Information ("ePHI") to me via unsecured text message/Internet/email. I expressly and unequivocally acknowledge that Lymphwell does not have the capability to send text messages/emails in an encrypted or secure format. I understand that my information may also be stored on a secure cloud-based database, and I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via text message/email. I fully understand the risks of transmitting unencrypted text messages/email containing ePHI, I am willing to accept those risks. I knowingly, intentionally, and voluntarily waive all rights, claims and damages relating to breach of confidentiality or other tort and all other legal claims that could be asserted against Lymphwell or any of its employees, agents, members as a result of any third person improperly accessing, using, or disclosing my PHI or ePHI as a result of transmission via text/email. I intend to be legally bound hereby.



Lymphwell

Lymphedema Specialty | Rehabilitation | Restorative Service | Wound Care | Compression & Bandages

By signing this form, you are certifying that you have read, agree, and understand everything in this document. For any questions regarding this agreement, you may contact our office manager; Lindy Ditmore @ lindy.ditmore@lymphwell.com via email, or you can call her at the office at 512.665.3288.

Patient Signature _____

Date _____