



12006 W. 87th St. Pkwy
Lenexa, Kansas 66215

913.601.8151 | **PWRPHYSIO.COM**

PATIENT NAME _____

DATE OF BIRTH _____ SEX _____ SSN _____

ADDRESS _____ APT # _____

CITY STATE ZIP CODE PHONE # _____

EMAIL _____

***** ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? YES / NO *****

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

EMERGENCY CONTACT _____

PHONE # _____ RELATIONSHIP _____

PRIMARY INSURANCE _____

MEMBER ID # _____ GROUP # _____

COPAY \$ _____ CO-INSURANCE \$ _____

REMAINING DEDUCTIBLE \$ _____ ESTIMATED COST PER VISIT \$ _____

ARE YOU THE PRIMARY SUBSCRIBER? YES / NO

IF NO, SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP _____

SECONDARY INSURANCE _____

MEMBER ID# _____ GROUP # _____

CO-INSURANCE % _____ REMAINING DEDUCTIBLE \$ _____

ARE YOU THE PRIMARY SUBSCRIBER? YES / NO

IF NO, SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP _____



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**** DO YOU WANT US TO BILL YOUR INSURANCE FOR SERVICES RENDERED? YES / NO ****

**** DO YOU AGREE TO PAY ALL COPAYS, DEDUCTIBLES, PATIENT RESPONSIBILITIES AND CANCELLATION FEES AS APPLICABLE AT THE TIME OF SERVICE? YES / NO ****

**** DO YOU WANT TO SELF PAY FOR SERVICES RENDERED? YES / NO ****

SELF PAY COST PER VISIT \$ _____

ONCE THE PAYMENT TYPE IS DETERMINED, WE ARE NOT ABLE TO CHANGE THE BILLING PROCESS

PAYMENT INFORMATION

WE ASK THAT YOU PAY FOR TREATMENT AT THE TIME OF YOUR VISIT. REGULAR EXCEPTION TO THIS POLICY ARE THOSE PATIENTS WITH WORKER'S COMPENSATION OR OTHER INSURANCE WHICH IS CONFIRMED FOR FULL PAYMENT. IF YOUR INSURANCE POLICY PAYS 80% AFTER YOUR DEDUCTIBLE, WE WILL ASK FOR PAYMENT UP TO THE AMOUNT OF THE DEDUCTIBLE PLUS 20% THEREAFTER. IT IS THE PATIENT'S RESPONSIBILITY TO CONFIRM THE POLICY PAYMENT. PLEASE OBTAIN CLAIM FORMS FROM YOUR INSURANCE COMPANY, FILL THEM OUT AND PRESENT THIS TO US FOR OUR BILLING.

EXCEPTIONS TO THIS ABOVE POLICY CAN BE MADE WITH *PRIOR APPROVAL* FOR EXAMPLE, PATIENTS WHO ARE SEEN FOR DAILY TREATMENTS MAY WISH TO PAY WEEKLY RATHER THAN DAILY. PAYMENT PLANS FOR PATIENTS WITHOUT INSURANCE OR IN FINANCIAL DIFFICULTY MAY BE SET UP WHEN NECESSARY. IF AN ACCIDENT CASE IS IN LITIGATION, WE ADHERE TO THE ABOVE POLICY AND *DO NOT WAIT* FOR PAYMENT WHEN THE COURT CASE IS CLOSED.

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I AGREE TO BE EVALUATED AND TREATED FOR PHYSICAL/OCCUPATIONAL THERAPY. I HEARBY CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS REQUIRED TO ACT ON THIS REQUEST. I REQUEST THAT PAYMENT OF BENEFITS BE MADE ON MY BEHALF TO PWR PHYSIO LLC. I UNDERSTAND THAT I MAY REQUEST A COPY OF THE PRIVACY PRACTICES AND/OR COPY OF MY PROTECTED HEALTH INFORMATION.

SIGNATURE _____ **DATE** _____

**** IS THIS INJURY A RESULT OF AN AUTO ACCIDENT? YES / NO ****

**** IS THIS A WORKER'S COMPENSATION CASE? YES / NO ****

CONTACT PERSON FOR THE CASE _____ PHONE # _____

CASE # _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

EMPLOYER PHONE # _____



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CANCELLATION POLICY

EFFECTIVE JANUARY 1, 2023

Due to the influx of patients and the demand for certain specific appointment times, we will be placing a cancellation policy into effect.

Please read and initial the below statements:

_____ The charge for a late cancellation (anything less than 12 hours in advance) will be \$25.00.

_____ The charge for a NO SHOW appointment will be \$75.00

We are required to hold a credit card on file for missed visits, deductibles and/or co-insurance payments according to your Explanation of Benefits received after service.

We will call you prior to charging your card to inform you of what the charge is and to give you the opportunity to use a different method of payment.

APPOINTMENT REMINDERS

Please chose and initial one of the options below:

_____ Confirm my appointments via auto-reminders at this number _____

_____ Do NOT conform my appointments via auto-reminders. I do not need reminders.

Patient name _____

Signature _____ Date _____



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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. This form is a “friendly” version for your convenience. A more complete text is available in the office. You have the right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office manager.

What this is about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, text or US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide the patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____ Date _____



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LYMPHEDEMA THERAPY PATIENT INTAKE FORM

Patient name: _____

DOB: _____

Referring MD: _____

Phone: _____

Specialist MD: _____

Phone: _____

SWELLING HISTORY body part: _____

I am currently experiencing:

Swelling

Rash

Shortness of breath

Pain

Weakness

Impaired motion

Numbness/tingling

Open

wounds

Heaviness/tightness/fullness

Skin changes: dry/discolored/weeping/
hardness

When did these issues begin? _____

Family history of same issues? YES/NO

THERAPY HISTORY body part: _____

When _____ Where _____

Are you currently seeing OT or PT for any concerns?

Are you currently receiving hospice or HOME HEALTH services that include nursing, PT, OT or ST?

YES / NO agency name and phone: _____



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Have you had lymphedema or lipedema therapy before? YES / NO

What treatments did you receive?:

Manual Lymph Drainage

Compression garments

Compression bandage
wrapping

Diuretics/water pill

Kinesio taping

Self manual lymph drainage

Antibiotics

Pneumatic compression

pump_____

Other:_____

Do you have any allergies to tape, latex or topical skin products? YES / NO

If you have pain, please rate on scale of 0 (no pain) to 10 (worst imaginable)

Current:_____ Worst:_____ Best:_____

Pain is

located:_____

Pain is: Sharp Dull Ache Heaviness Burning Constant

Other:_____

RENA Sculpt Release

I understand that I may feel intense muscle contractions in the treated area, but I will have control over the intensity and length of the treatment. I can stop the treatment at any time for any reason. **Initials:** _____

I acknowledge that the treatment is preferably applied directly over the skin. If it is not, I am aware not to wear any **metallic** accessories (such as jewelry, watch or clothes containing metallic threads) and to **remove** my phone and wallet during the treatment. **Initials:** _____

Please circle any of the following you currently have or have had:

- Metal or electronic implants
- Cardiac pacemakers, implanted defibrillators, implanted neurostimulators
- Drug pumps
- History of abdominal surgery
- Pulmonary insufficiency
- Malignant tumor
- Metallic IUD
- Hemorrhagic conditions
- Heart disorders
- Epilepsy
- Recent surgical procedures (muscle contraction may disrupt the healing)
- Areas of the skin which lack normal sensation
- Current pregnancy or trying to get pregnant

If you circled any of these questions, please specify:

Please answer the following:

- Have you been pregnant? Y N
 - Have you had a C-section? Y N
 - Have you had a Vaginal birth? Y N
- _____

Treatment considerations

- I am aware that the treatment cannot be applied over the head, heart, or neck and that I should notify my therapist if I would like the paddles moved. **Initials:** _____
- I am aware that pregnancy and nursing are contraindicated, and pregnant women cannot undergo the treatment. **Initials:** _____
- I understand that there are certain risks associated with Renasculpt treatments and they include but are not limited to muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. **Initials:** _____
- I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials:** _____
- I have read the above information, and I request and give my consent to be treated with the Renasculpt by the practitioners in this practice and designated staff. **Initials:** _____

My signature below indicates that the above information is accurate and current.

Patient's signature: _____

Date: _____

Witness (in print): _____

Signature: _____ **Date:** _____

Practice Name: _____



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MY WELLNESS JOURNEY

PATIENT NAME _____ DOB _____

THE MAIN REASON I AM SEEKING THERAPY IS:

MY MOST IMPORTANT GOALS FOR THERAPY ARE:

1. _____
2. _____
3. _____

I KNOW I AM COMPLETE WITH THERAPY WHEN:

*****THERAPIST ONLY*****

FREQUENCY/DURATION: _____

THERAPY PLAN OF CARE:

PATIENT SIGNATURE: _____