Name: Date:
Address
City: State: Zip:
Sex: [ ] M [ ] F Date of Birth:
Do you have Medicare? Yes/No **Dr. Byrd has opted out of Medicare/Medicaid/Tricare. No services/procedures provided in our facility can be submitted to Medicare/Medicaid/Tricare by our office or the patient.** Current Insurance Provider:
Patient Agreement for Communications I understand that as part of my healthcare Lipedema Surgery Center will need to contact me from time to time. **I hereby authorize you to contact me in the following ways and leave messages at the following numbers:**
Home Phone :
Cell Phone :
Work Phone :
E-mail:
If you would like us to be able to discuss your healthcare with anyone (i.e. family member), please list: Name: Relationship Phone #
Emergency Contact Person:
How did you learn of our practice?
Are you allergic to any medications? Yes or No If Yes, please list:
The undersigned authorizes treatment and procedures performed by the physician and employees of the center and understand that no guarantee is made as to the results that may be obtained. All professional services rendered are charged to the patient. The PATIENT is responsible and agrees to pay for all services. The patient understands that Dr. Byrd has opted out of Medicare and Medicare will not reimburse for any charges incurred in our office. I authorize the release of all of my medical records for the purpose of treatment, payment, and health-care operations. I acknowledge that HIPAA privacy practices are available to me at my request.
Signature:

LIPEDEMA QUESTIONNAIRE

NAME _____ DATE_____

How were you referred to Dr. Byrd? Internet, Facebook, physician, etc.

_____

_____

Date of diagnosis_____ Name and specialty of physician making diagnosis:

_____

_____

(Circle appropriate answers)

Areas of concern currently: Arms Legs Buttocks Abdomen

Where did swelling start: Arms Legs Buttocks Abdomen

When did swelling start:_____

Progressive worsening of condition with age: Yes No

Tired heavy legs -sometimes with swelling increasing at the end of the day: Yes No

Problem with movement and gait: Yes No Please describe below:

_____

_____

Joint problems: Yes No Please describe below:

_____

_____

Cuffs or bulges around ankles or wrists: Yes No

History of easy bruising (with or without injury): Yes No

Hands and feet affected: Yes No

Are affected areas painful to touch or pressure: Yes No

Average daily pain on a scale from 1 to 10: _____

Pain level on a 'bad' day on a scale from 1 to 10: _____

Number of pregnancies: _____ Number **of live births:** _____

Changes after pregnancy: Yes No Please describe below:

Functional Impairment

- ☐ Getting in and out of bath
- ☐ Walking between rooms
- ☐ Walking two blocks
- ☐ Walking a mile
- ☐ Navigating stairs
- ☐ Squatting
- ☐ Pushing up on your hands (e.g., from bathtub or chair)
- ☐ Lifting an object, like a bag of groceries from the floor
- ☐ Laundering clothes
- ☐ Performing light activities around home
- ☐ Performing heavy duties around home
- ☐ Vacuuming, sweeping, or raking
- ☐ Sitting for one hour
- ☐ Standing for one hour
- ☐ Running
- ☐ Rolling over in bed
- ☐ Grooming Hair
- ☐ Preparing food
- ☐ Driving
- ☐ Getting into or out of car
- ☐ Dressing
- ☐ Putting on shoes or socks
- ☐ Tying or lacing shoes
- ☐ Sleeping

History of Dercum's Yes No

Ehlers-Danlos syndrome: Yes No

Occupation: _____

Previous therapies for lipedema/lymphedema:

MLD:	Yes	No	Length of treatment_____
Compression garments:	Yes	No	Length of treatment_____
Exercise:	Yes	No	Length of treatment_____
Diet:	Yes	No	What type_____

Have you used a compression pump? [] Yes [] No

If so, please provide the following information:

Manufacturer and model #, if known _____

Time period of usage _____

Why discontinued?_____

Highest weight (excluding pregnancy):_____ Lowest adult weight:_____

Height: _____ **Current Weight:** _____

PAST MEDICAL HISTORY: Have you ever had any of the following conditions?

- [] High blood pressure
- [] Diabetes
- [] Clotting disorders
- [] Deep vein thrombosis (DVT)
- [] Rheumatic illnesses
- [] Liver disease

[] High cholesterol
[] Kidney disease
[] Arthritis. If so, what type? _____
[] Other_____
_____

PAST SURGICAL HISTORY: Have you had any of the following?

[] Varicose vein operation Date of procedure: _____
[] Bariatric surgery
[] Injuries. _____
[] Please list all surgeries with date of procedure: _____
_____
_____

MEDICATIONS: Please list current medications and dosages. INCLUDE ALL SUPPLEMENTS AND VITAMINS.

_____
_____
_____

ALLERGIES:

Do you have allergies to **medications** Yes or No, or **Environmentals**? Yes or No
If yes, please list: _____
_____
_____

FAMILY HISTORY:

Do close relatives have?	Relation
[] Lipedema	_____
[] Heart disease	_____
[] High cholesterol	_____
[] Kidney disease	_____
[] Circulatory problems	_____
[] Blood clotting problems	_____
[] Thrombosis (DVT) or lung embolism	_____
[] Diabetes	_____
[] Thyroid disease	_____
[] High blood pressure	_____
[] Stroke	_____
[] Lipomas	_____

SOCIAL HISTORY:

Are you married? Yes or No
Do you smoke? Yes or No
Do you drink? Yes or No

Spouse name_____
If yes, how much? _____
If yes, how much? _____

REVIEW OF SYSTEMS

Do you have any of the following symptoms:

GENERAL:

[] Fatigue
[] Fever or chills
[] Weakness
[] Trouble sleeping

SKIN:
[] Rashes
[] Lumps
[] Itching
[] Dryness
[] Color changes
[] Hair or nail changes

HEAD:
[] Headache
[] Head injury
[] Neck pain

EARS:
[] Decreased hearing
[] Ringing in ears
[] Earache
[] Drainage

EYES:
[] Vision loss/changes
[] Pain
[] Redness
[] Blurry or double vision
[] Flashing lights
[] Specks
[] Glaucoma
[] Cataracts

NOSE:

[] Stuffiness
[] Discharge
[] Itching
[] Hay fever
[] Nosebleeds
[] Sinus pain

THROAT:
[] Bleeding
[] Dentures
[] Sore tongue
[] Dry mouth
[] Sore throat
[] Hoarseness
[] Thrush
[] Non-healing sores

NECK:
[] Lumps
[] Swollen glands
[] Pain
[] Stiffness

BREASTS:
[] Lumps
[] Pain
[] Discharge

RESPIRATORY:
[] Cough
[] Sputum
[] Coughing up blood
[] Shortness of breath
[] Wheezing
[] Painful breathing

CARDIOVASCULAR:
[] Chest pain or discomfort
[] Tightness
[] Palpitations
[] Shortness of breath with activity
[] Difficulty breathing lying down
[] Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL:
[] Swallowing difficulties
[] Heartburn
[] Change in appetite
[] Nausea

[] Change in bowel habits
[] Rectal bleeding
[] Constipation
[] Diarrhea
[] Yellow eyes or skin

URINARY:
[] Frequency
[] Urgency
[] Burning or pain with urination
[] Blood in urine
[] Incontinence
[] Change in urinary strength

MUSCULOSKELETAL:
[] Muscle or joint pain
[] Stiffness
[] Back pain
[] Redness of joints
[] Swelling of joints
[] Trauma

NEUROLOGIC:
[] Dizziness
[] Fainting
[] Seizures
[] Weakness
[] Numbness
[] Tingling
[] Tremor

HEMATOLOGIC:
[] Easy bruising
[] Ease of bleeding

ENDOCRINE:
[] Heat or cold intolerance
[] Sweating
[] Frequent urination
[] Unusual thirst
[] Change in appetite

PSYCHIATRIC:
[] Nervousness
[] Stress
[] Depression
[] Memory loss

VASCULAR:
[] Calf pain with walking
[] Leg cramping

Insurance

Our office is not in network with any insurance companies, but we will assist in preparing your documents and getting it pre-approved. We will also appeal any denied claims on your behalf. **Payment for surgery is required up front if your insurance company does not allow for Single Case Agreements (SCA). Any reimbursement from the insurance company goes directly to you.** Sometimes the insurance companies want to set up a peer-to-peer review with Dr. Byrd to discuss the case and she is happy to do that. If there is anything you need, please do not hesitate to contact us.

The first step is to complete the packet and have a consultation with Dr. Byrd to see if you are a candidate for surgery. We will need to see you in person to prepare the necessary documents for your insurance company. There is a $200.00 charge for the office visit.

Our office has opted out of Medicare. All patients are required to sign the Opt Out Medicare Waiver. Neither our office, nor the patient can send any documents into Medicare or Medicaid for any procedures done here in our office.

Procedure codes used: 15879-22,50

15878-22,50

15877-22

Diagnostic codes are: I89.0, M79.609, R20.8 and R26.9

I understand that Dr. Byrd has opted out of Medicare and Tricare and I am unable to use Medicare and/or Tricare in this office for any procedures or visits.

Name_____Signature_____Date_____

Consultations

Consultations are $200.00. We will take a non-refundable $50.00 deposit to book the appointment and the remaining $150.00 will be due the day of the consultation. Our surgery coordinator will contact you once you have returned the completed paperwork to schedule the appointment.

Name_____Signature_____Date_____

Patient HIPAA Release Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule.

A Copy of this law and policy is available to you upon request.

The Doctor and Staff at Lipedema Surgery Center have my permission to release my medical and personal information to:

List Names and Relationship of who you would like your information shared with:

_____

_____

Name_____Signature_____Date_____

ALL PATIENTS MUST SIGN to acknowledge that Dr. Byrd has opted out of Medicare

*****MEDICARE PRIVATE CONTRACT IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D**

This contract is entered into by and between Marcia V Byrd, MD (hereinafter called "physician"), whose principal medical office is located at 11050 Crabapple Road Roswell, GA 30075 and _____ (hereinafter called "beneficiary"), who resides at _____, and shall become effective on this __ day of _____, 20__ and shall expire on the 28th day of April 28, 2026 (the "opt out period"), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

The physician acknowledges that she is "opted out" (excluded) from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act. The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that she must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that she must enter into a contract for each opt-out period.

Beneficiary Obligations The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative before items or services have been furnished to the beneficiary under the terms of this contract.

I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Marcia V Byrd MD

_____ _____

Signature of Physician *Date*

11050 Crabapple Rd Roswell, GA (770)587-1711
Principal Office Address Telephone Number
1932112703
National Provider Identifier

_____ _____

Name of Beneficiary (printed) or His/Her Legal Representative *Date*

_____

Signature of beneficiary or His/Her Legal Representative

_____ _____

Telephone Number *Home Address*