**HEALTHY LYMPHATICS OF NC, PC**

**Phone: 828-355-9584**

**Fax: 828-355-9689**

**Healthy Lymphatics-Boone office Healthy Lymphatics-Elkin office Healthy Lymphatics-Mt. Airy office**

**450 New Market Blvd Ste 3 2015 North Bridge St 905 Rockford St**

**Boone, NC 28607 Elkin, NC 28621 Mount Airy, NC 27030**

**Healthy Lymphatics-North Wilkesboro office Healthy Lymphatics-Galax VA office**

**1912 West Park Drive 812 West Stuart Drive**

**North Wilkesboro, NC 28659 Galax, VA 24333**

**APPOINTMENT DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TIME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LOCATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT’S HOME HEALTH FORM**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CERTIFY THAT I HAVE INFORMED**

**HEALTHY LYMPHATICS STAFF OR THERAPIST THAT I AM NOT CURRENTLY RECEIVING**

**ANY TYPE OF HOME HEALTH SERVICES AND NO ONE COMES TO MY HOME FROM**

**A HOME HEALTH COMPANY TO HELP ME WITH ANY CARE. I WILL ALSO LET**

**HEALTHY LYMPHATICS KNOW IF I HAVE RECEIVED HOME HEALTH SERVICES WITHIN**

**THE LAST 6 MONTHS, I WILL PROVIDE THEM WITH THE NAME OF THE HOME**

**HEALTH COMPANY. I UNDERSTAND THAT MY INSURANCE COMPANY WILL NOT PAY**

**FOR MY TREATMENT AT HEALTHY LYMPHATICS IF I AM STILL UNDER THE CARE OF A**

**HOME HEALTH AGENCY. IF MY INSURANCE COMPANY INFORMS HEALTHY**

**LYMPHATICS THAT I AM STILL UNDER HOME HEALTH CARE, I WILL BE**

**RESPONSIBLE FOR THE ENTIRE COST OF MY TREATMENT AT HEALTHY LYMPHATICS.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT PRINT NAME**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE**