

PATIENT INFORMATION					
LAST NAME		FIRST NAME		MI	<b>GARMENT SET(S) REQUIRED</b> LEFT    RIGHT Upper extremity <input type="checkbox"/> <input type="checkbox"/> Lower extremity <input type="checkbox"/> <input type="checkbox"/>
ADDRESS					
CITY			STATE	ZIP	
PRIMARY PHONE	SECONDARY PHONE <input type="checkbox"/> CELL <input type="checkbox"/> WORK <input type="checkbox"/> OTHER		FAX	EMAIL	
DATE OF BIRTH	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male		SOCIAL SECURITY NUMBER		
EMPLOYER		EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE	
How did you hear about the Flexitouch System? <input type="checkbox"/> Physician <input type="checkbox"/> Therapist <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Advertisement <input type="checkbox"/> Other: _____					
INSURANCE INFORMATION					
TYPE OF INSURANCE PLEASE CHECK <input type="checkbox"/> PRIVATE HEALTH INSURANCE <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> SELF-PAY					
DATE OF INJURY IF WORKER'S COMP		WORKER'S COMP CLAIM NUMBER			
PRIMARY INSURANCE COMPANY				PHONE NUMBER	
NAME OF POLICY HOLDER			PATIENT'S RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
DATE OF BIRTH OF POLICY HOLDER			EMPLOYER		
IDENTIFICATION NUMBER		GROUP NUMBER			
SECONDARY INSURANCE COMPANY				PHONE NUMBER	
NAME OF POLICY HOLDER		DATE OF BIRTH OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
IDENTIFICATION NUMBER		GROUP NUMBER			
PHYSICIAN INFORMATION					
PRESCRIBING PHYSICIAN'S NAME				NPI (NATIONAL PROVIDER IDENTIFIER)	
CLINIC NAME		PHONE		FAX	
ADDRESS		CITY		STATE	ZIP
THERAPIST INFORMATION			FACILITY/CLINIC INFORMATION		
THERAPIST'S NAME			FACILITY/CLINIC NAME		
WORK EMAIL    APPROVED TO EMAIL DOCUMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO			ADDRESS		
PHONE		FAX	CITY		STATE    ZIP



**PRESCRIPTION FOR E0652 PNEUMATIC COMPRESSION DEVICE  
FLEXITOUCH® SYSTEM**

Place Copy in  
Patient's Medical Chart

PATIENT INFORMATION		SUPPLIER INFORMATION	
NAME	DOB	TACTILE SYSTEMS TECHNOLOGY, INC. 1331 Tyler Street NE, Suite 200 Minneapolis, MN 55413 Phone: 866.435.3948 FAX: 866.435.3949 NPI: 1427131424	
ADDRESS			
CITY/STATE/ZIP	PHONE		

**MEDICAL NECESSITY INFORMATION (Information in this section may not be completed by the supplier of the item)**

**Diagnosis**

- |  |  |
|--|--|
| <input type="checkbox"/> Postmastectomy Lymphedema (457.0) | <input type="checkbox"/> Secondary Lymphedema (457.1)  |
| <input type="checkbox"/> Primary Lymphedema (757.0)        | <input type="checkbox"/> Secondary Lymphedema (457.1) 2° Chronic Venous Insufficiency (459.81) |

**Lymphedema is caused by:**

**Cancer**

- |  |  |
|--|--|
| <input type="checkbox"/> Breast        | <input type="checkbox"/> Melanoma          |
| <input type="checkbox"/> Gynecological | <input type="checkbox"/> Sarcoma           |
| <input type="checkbox"/> Prostate      | <input type="checkbox"/> Other/Type: _____ |

**Non-Cancer**

- |   |   |
|---|---|
| <input type="checkbox"/> Obesity          | <input type="checkbox"/> Surgery: _____ |
| <input type="checkbox"/> Trauma: _____    | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Infection: _____ |   |

**Patient tried and failed\* home treatments (bandaging/garments/exercise/elevation) for at least 4 weeks?**  YES  NO

*\*Failure defined as significant symptoms remain or no significant improvement.*

**Patient is CURRENTLY experiencing the following complications/impairments from Lymphedema:**

- |   |  |  |                                       |   |
|---|--|--|---------------------------------------|---|
| <input type="checkbox"/> Unable to control swelling | <input type="checkbox"/> Infections    | <input type="checkbox"/> Fibrosis            | <input type="checkbox"/> Pain         | <input type="checkbox"/> Compromised skin integrity |
| <input type="checkbox"/> Impaired ROM               | <input type="checkbox"/> Impaired ADLs | <input type="checkbox"/> Psychosocial issues | <input type="checkbox"/> Loss of work |   |

**Patient tried a basic\*\* pump for at least 4 weeks?**  YES  NO

*\*\*A "basic" pump (E0651) is defined as a non-calibrated pressure pump with no programmability.*

**A basic\*\* pump is/was not appropriate for patient because:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Unable to tolerate pressure | <input type="checkbox"/> Exacerbated symptoms       | <input type="checkbox"/> Developed fibrotic cuff      | <input type="checkbox"/> Truncal edema |
| <input type="checkbox"/> Genital edema               | <input type="checkbox"/> Compromised skin integrity | <input type="checkbox"/> Not recommended by clinician | <input type="checkbox"/> Other _____   |

**PRESCRIPTION FOR THE FLEXITOUCH SYSTEM**

**Program Frequency (Select one)**

**Unilateral**

- 1 treatment daily.  
 2 treatments daily.  
 \_\_\_ treatment(s) daily for \_\_\_ weeks, then 1 treatment daily thereafter.

**Bilateral**

- 1 treatment every A.M. for left extremity; 1 treatment every P.M. for right extremity.  
 1 treatment one day for left extremity followed by 1 treatment next day for right extremity; continue alternating daily.

**Program Selection and Duration (Check all that apply)**

REGION	PROGRAM	APPROX. TIME
<input type="checkbox"/> Upper Extremity: Full treatment	U1	60 minutes
<input type="checkbox"/> Lower Extremity: Full treatment	L1	60 minutes
<input type="checkbox"/> Other: _____		

**Anatomic Regions with Edema (Check all that apply)**

- |                 |                          |                          |                                |   |
|-----------------|--------------------------|--------------------------|--------------------------------|---|
|                 | <u>LEFT</u>              | <u>RIGHT</u>             |                                |   |
| Upper Extremity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest | <input type="checkbox"/> Trunk            |
| Lower Extremity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back  | <input type="checkbox"/> Genital/Perineum |

**Distal Pressure (Select one)**

- Normal  
 Increased

**Length of Need (Select one)**

- Lifetime (over 13 months)  
 Other: \_\_\_\_\_

**NAME OF PERSON COMPLETING FORM IF OTHER THAN PHYSICIAN**

NAME	PHONE
SIGNATURE	FACILITY/CLINIC

**PHYSICIAN CERTIFICATION AND SIGNATURE.** I certify that this patient is under my care, the equipment is medically necessary, and there are currently no contraindications\* that prohibit use of the prescribed equipment. I also certify that the medical information above is true and accurate to the best of my knowledge and that I have reviewed and concur with all recommendations made by the therapist/clinician listed above with regard to lymphedema care and treatment, including the need for this pneumatic compression therapy in the home.

**\*Infections/inflammation, deep vein thrombosis [DVT], increased lymphatic return is undesirable, acute cancer, thrombophlebitis, episodes of pulmonary embolism, congestive heart failure [CHF] and pulmonary edema.**

PRESCRIBER'S NAME	DATE (Required)	PRESCRIBER'S SIGNATURE	NPI
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NAME LAST	FIRST	MI	DOB
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**GARMENT SET INFORMATION**

<b>GARMENT SET(S) REQUIRED:</b> UPPER EXTREMITY <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT LOWER EXTREMITY <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	HEIGHT	WEIGHT
--	--------	--------

**MEASUREMENT INFORMATION**

<b>OPTION ONE</b>	MEASUREMENTS ONLY: Complete if Flexitouch demonstration <b>WAS NOT</b> performed.																																							
Enter measurements for <b>ALL</b> affected limbs.			<b>COMMENTS:</b>  <input type="checkbox"/> Check box if a Spanish User Guide is needed.																																					
<table border="1"> <thead> <tr> <th colspan="3">UPPER EXTREMITY MEASUREMENTS (cm)</th> </tr> </thead> <tbody> <tr> <td>Arm Inseam</td> <td colspan="2"></td> </tr> <tr> <td>Waist</td> <td colspan="2"></td> </tr> <tr> <td>Chest</td> <td colspan="2"></td> </tr> <tr> <td></td> <td>LEFT</td> <td>RIGHT</td> </tr> <tr> <td>Bicep</td> <td></td> <td></td> </tr> </tbody> </table>		UPPER EXTREMITY MEASUREMENTS (cm)			Arm Inseam			Waist			Chest				LEFT	RIGHT	Bicep			<table border="1"> <thead> <tr> <th colspan="3">LOWER EXTREMITY MEASUREMENTS (cm)</th> </tr> </thead> <tbody> <tr> <td>Leg Inseam</td> <td colspan="2"></td> </tr> <tr> <td>Hips</td> <td colspan="2"></td> </tr> <tr> <td></td> <td>LEFT</td> <td>RIGHT</td> </tr> <tr> <td>Thigh</td> <td></td> <td></td> </tr> <tr> <td>Calf</td> <td></td> <td></td> </tr> </tbody> </table>		LOWER EXTREMITY MEASUREMENTS (cm)			Leg Inseam			Hips				LEFT	RIGHT	Thigh			Calf			
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<b>OPTION TWO</b>	MEASUREMENTS AND DEMONSTRATION RESULTS: Complete if Flexitouch demonstration <b>WAS</b> performed.		
Demonstration requested by:			
CLINICIAN'S NAME		DATE REQUESTED	

Does the patient **currently** have any of the contraindications listed?  **No**  **Yes** (Please indicate below, check all that apply)

Infections/Inflammation   
  Deep Vein Thrombosis (DVT)   
  Increased Lymphatic Return is undesirable   
  Acute Cancer  
 Thrombophlebitis   
  Episodes of Pulmonary Embolism   
  Congestive Heart Failure (CHF)   
  Pulmonary Edema

DATE OF DEMONSTRATION:	LOCATION OF DEMONSTRATION: <input type="checkbox"/> Home <input type="checkbox"/> Clinic	PERFORMED BY (SIGNATURE)
------------------------	---	--------------------------

Enter **PRE**-measurements for **ALL** affected limbs. Enter **PRE- and POST**-measurements for limb(s) receiving demonstration treatment.

UPPER EXTREMITY MEASUREMENTS (cm)					LOWER EXTREMITY MEASUREMENTS (cm)				
Arm Inseam					Leg Inseam				
Waist	PRE	POST		Hips	PRE	POST			
Chest	PRE	POST			LEFT		RIGHT		
	LEFT		RIGHT		PRE	POST	PRE	POST	
	PRE	POST	PRE	POST					
Bicep					Thigh				
Forearm					Knee				
Wrist					Calf				
					Ankle				

<b>CLINICAL RESPONSE TO TREATMENT</b> Patient is capable of donning/doffing the garments or they have a caregiver capable of assisting them to don/doff the garments? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is able to tolerate the treatment session? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>COMMENTS:</b>  <input type="checkbox"/> Check box if a Spanish User Guide is needed.
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**PATIENT'S SIGNATURE**  
I received a demonstration for the Flexitouch System and the information above is true and accurate to the best of my knowledge.

PATIENT'S NAME (Please print)	PATIENT'S SIGNATURE	DATE
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## Consent for the Use and Disclosure of Protected Health Information

I understand that Tactile Systems Technology, Inc. (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and health care operations.

I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices.

I consent to the release of PHI by Tactile to my health care providers and insurance company(ies). I authorize and consent to the release by my health care providers to Tactile and any insurance company(ies), all PHI necessary to secure payment for the Flexitouch® system (Flexitouch).

I understand Tactile may desire to review de-identified health information for the purposes of clinical research, evaluation of patient outcomes, or clinical protocol development. I consent to the release and use of my de-identified information so long as Tactile ensures that I cannot be identified through release and use of that information.

## Assignment of Benefits

I assign payment of medical benefits for the Flexitouch system to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs of the Flexitouch not covered by my insurance are my responsibility.

## Consent to Leave Messages

I authorize Tactile to leave voice mail messages for me regarding medical and/or billing information at the following number(s):

( \_\_\_\_\_ ) \_\_\_\_\_  Day  Evening ( \_\_\_\_\_ ) \_\_\_\_\_  Day  Evening

I authorize Tactile to leave messages with or respond to inquiries from the following individual(s):

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I do not authorize Tactile to leave voice mail messages containing medical or billing information.

## Consent to Email

I grant permission to use the email address provided for the sole purpose of communicating with me regarding my Flexitouch system order.

\_\_\_\_\_ Email Address

**By signing this, I agree to all the terms and conditions listed above.**

_____	_____	_____
Patient Name (Please print)	Patient Signature	Date
_____	_____	_____
Guardian Name (If applicable, please print)	Guardian Signature	Date

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Please return completed form to Tactile Systems Technology, Inc.  
**Mail:** 1331 Tyler Street NE, Suite 200, Minneapolis, MN 55413 **Fax:** 866.435.3949  
**To speak with a Patient Services representative, call toll-free:** 866.435.3948



# Tactile Systems Technology, Inc.

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

### Uses and Disclosures

*Treatment.* Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

*Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

*Health care operations.* Your health information may be used as necessary to support the day-to-day activities and management of Tactile Systems Technology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

*Law enforcement.* Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

*Public health reporting.* Your health information may be disclosed to public health agencies as required by law.

*Other uses and disclosures require your authorization.* Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### Additional Uses of Information

*Information about treatments.* Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

### Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications

- concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

### Tactile Systems Technology's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

### Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer  
Tactile Systems Technology, Inc.  
1331 Tyler Street NE, Suite 200  
Minneapolis, MN 55413

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

### Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer  
Tactile Systems Technology, Inc.  
1331 Tyler Street NE, Suite 200  
Minneapolis, MN 55413  
612-355-5100

### Effective Date

This Notice is effective on or after April 14, 2003.

D/N: 01-2125 Rev C 12/2009

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**(PATIENT COPY)**