Welcome to Advantage Therapy and Rehabilitation LLC

At Advantage Therapy and Rehabilitation, we are dedicated to providing exceptional care and personalized rehabilitation services to help you achieve your best possible outcomes. Whether you're seeking physical therapy to regain strength and mobility, occupational therapy to restore daily function, or speech therapy to enhance communication skills, our experienced team is here to guide you every step of the way.

Our therapists take a holistic approach, focusing on your unique needs and goals to create customized treatment plans designed for your recovery. We combine advanced therapeutic techniques with compassionate care, ensuring a positive and supportive environment for healing.

We are movement experts with advanced degrees in our field. Several of our clinicians received their Doctorates in their respective fields. We practice patient-centered care to improve the quality fo your life.

At Advantage Therapy and Rehabilitation, your health and well-being are our top priorities. Our goal is to help you live life to the fullest by providing high-quality therapy services that promote long-term recovery and improved quality of life.

Thank you for choosing us as your partner in your rehabilitation journey. We look forward to working with you!

Advantage
Therapy & Rehabilitation

Physical Activity Readiness Questionnaire (PAR-Q)

We care about your safety during physical activity. The following questions will help us determine if you need to consult a doctor before engaging in any exercise or therapy. Please complete the form honestly.

Full Name: _____ Phone Number: _____

Date of Birth: _____ Date: _____

Please answer YES or NO to the following:

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

Yes ☐ No ☐

2. Do you feel pain in your chest when you perform physical activity?

Yes ☐ No ☐

3. In the past month, have you had chest pain when you were not performing physical activity?

Yes ☐ No ☐

4. Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes ☐ No ☐

5. Do you have a bone or joint problem (e.g., back, knee, or hip) that could be made worse by a change in your physical activity?

Yes ☐ No ☐

6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

Yes ☐ No ☐

7. Do you know of any other reason why you should not do physical activity?

Yes ☐ No ☐

Health History

Please indicate if you have experienced or are currently experiencing any of the following:

(Check all that apply)

☐ High blood pressure

☐ High cholesterol

☐ Diabetes

☐ Asthma or other respiratory conditions

☐ Previous surgeries or injuries (please list): _____

☐ Other medical conditions:

_____

Emergency Contact Information

Emergency Contact Name: _____

Relationship to Patient: _____

Phone Number: _____

Consent

I have read, understood, and completed this questionnaire. I acknowledge that my responses are true and accurate to the best of my knowledge. If my health changes so that I could answer YES to any of the above questions, I will inform Advantage Therapy and Rehabilitation LLC immediately. I also agree to follow any recommendations from my healthcare provider or therapist.

Patient Signature: _____

Date: _____

For Office Use Only

Reviewed By: _____

Date: _____

Financial Agreement

At Advantage Therapy and Rehabilitation, we strive to provide you with the highest quality care while ensuring a flexible and convenient payment process. For those whose charges are counted towards deductible, the following payment plan can be used or payments can be made at the time of service.

Payment Plan for Deductibles and Coinsurance:

- **IF your deductible is NOT met we will collect 80 dollars/visit that will be applied to your deductible.**
- **IF your deductible HAS been met and you have a co-insurance we will collect 20 dollars to reflect a co-insurance**

Copays:

- **copayment will be collected at the time of service.**

We are legally bound to collect copayments, co-insurance, and deductibles from our contracts with your insurance company. They automatically accredit balances towards your deductible.

This new policy decreases the likeliness of a “surprise” bill coming at the end of treatment and allows for smaller payments to be made.

We appreciate your understanding and cooperation with these updates. Should you have any questions or need further clarification, please feel free to contact our billing department at **765-201-0071**.

Thank you for choosing Advantage Therapy and Rehabilitation for your care.

Please sign below to agree to the financial agreement.

Patient or POA:_____

Date: _____

Insurance Policy Holder Information

Name of Policy Holder:_____ Gender:_____

Date of Birth of Policy Holder:_____

Address of Policy Holder:_____

Consent to Care

I understand that Advantage Therapy and Rehabilitation will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I do hereby agree and give my consent for Advantage Therapy and Rehabilitation to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I hereby certify that all the above information is true to the best of my knowledge.

By signing below I certify that I am over 18 years of age. If the patient is a minor please have the parent/guardian sign below.

Patient or POA:_____

Date: _____

Advantage Therapy and Rehabilitation, LLC
HIPAA CONSENT FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO OUR PATIENTS:

Patient information will be maintained by Advantage Therapy and Rehabilitation, LLC as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with federal and state regulations. Below is a copy of the Notice of Privacy Practices.

Advantage Therapy and Rehabilitation reserves the right to release your healthcare information based upon a decision by your physician for medical emergencies and in general for continuity of care. We will release your healthcare information to third-party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work-related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

We reserve the right to:

- Call you to remind you of your next appointment and/or leave information on your answering machine
- Release your health information to your insurance company upon request and your primary care provider/referring provider as requested.
- Release your health information to anyone listed below:

Name	Relationship
_____	_____
_____	_____
_____	_____

By signing below I certify that I am over 18 years of age. If the patient is a minor please have the parent/guardian sign below.

Signature or patient or POA:_____

Date:_____