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 of 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

Patient Information Form

Patient Demographic Information				
***Last Name**	***First Name**			***Middle Initial**
Address	Apt/Bldg/Ste#	City	State	Zip Code
***Home Phone**	***Appointment Reminder Contact Method** ☐Email ☐No Appointment Reminder			
***Mobile Phone**	***Email Address** ☐Declined Email ☐No Email			
***Date of Birth**	***Sex** ☐F ☐M	Status ☐Single ☐Married ☐Other		
Height:	Weight:			
Falls This year? If so, how many_____	Imaging Completed? (MRI, X-RAY, CT Scan?):			

Employer Information			
Employer	Employment Status ☐ FT ☐PT ☐None ☐Retired ☐Student		
Address	City	State	Zip Code
Work Phone	Occupation		

Emergency Contact Information		
Contact Name	Phone	Relationship

Physician Information		
***Referring Physician**	Phone	Script Date
***Primary Care Provider (if different than above)**		

Additional Questions			
Injury /Onset Date	Post-Surgical ☐Yes ☐No	Surgery Date	***Body Part**
Work Related ☐Yes ☐No	Accident Related ☐Yes ☐No	Auto Related ☐Yes ☐No	Attorney Involved ☐Yes ☐No
Adjuster/Nurse Cases Mgr.	Phone	Attorney	Phone
Have you had prior therapy this year? (PT/OT/SP/Chiro) ☐Yes ☐No		How did you hear about us?	

Medicare ONLY! Additional Questions			
If Medicare, are you currently receiving home health services? ☐Yes ☐No			
If yes, the name of the agency:		If discharged what is the last date of service?	
Are you currently residing in a skilled nursing facility? If yes, the name of the facility:			
Primary Insurance Plan Information		**Secondary Insurance Plan Information**	
***Insurance/Plan**		***Insurance/Plan**	
***Policy ID #**		***Policy ID #**	
***Group #**		***Group #**	
***Insurance Phone**		***Insurance Phone**	
***Are you the policyholder?** ☐Yes ☐No If no, continue		***Are you the policyholder?** ☐Yes ☐No If no, continue	
***Policy Holder Name**	***DOB**	***Policy Holder Name**	***DOB**
***Patient relationship to policy holder:** ☐Self ☐Spouse ☐Child		***Patient relationship to policy holder:** ☐Self ☐Spouse ☐Child	
Patient, please initial here if the above information is correct and complete		Date	

**Office staff use ONLY (below) - ****For digital intake, only the fields highlighted/italicized are required*		
Intake completed by Date		***Date Eval Scheduled**
Registered by Date		Acct #
The patient Service Specialist will initial next to each task below once completed.		
Billing Disclosure added in Comments☐	Verified DL/Photo ID☐	Consent to receive calls and/or text messages, reviewed with the patient. If the patient agrees and signed consent, is text enabled box checked in TS?☐

Last updated 10/16/2024

Medical History

Acquired Respiratory Distress Syndrome	Yes	No	Allergies	Yes	No
Angina	Yes	No	Headaches	Yes	No
Anxiety	Yes	No	Back Injury	Yes	No
Asthma	Yes	No	Bleeding Disorder	Yes	No
COPD	Yes	No	Bowel/Bladder Abnormalities	Yes	No
Degenerative Disc Disease	Yes	No	Cancer	Yes	No
Depression	Yes	No	COVID-19 - If Yes, Date:	Yes	No
Diabetes	Yes	No	Dizzy or Fainting Spells	Yes	No
Emphysema	Yes	No	Epilepsy or Seizure Disorder	Yes	No
Hearing Loss	Yes	No	Fractures	Yes	No
Heart Attack	Yes	No	Hepatitis A, B, or C	Yes	No
Multiple Sclerosis	Yes	No	Hernia	Yes	No
Osteoporosis	Yes	No	High Blood Pressure	Yes	No
Parkinson's Disease	Yes	No	HIV/ AIDS	Yes	No
Peripheral Vascular Disease	Yes	No	Hypoglycemia	Yes	No
Stroke or TIA	Yes	No	Immunosuppressant Condition or medication	Yes	No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	Yes	No	Kidney Problems	Yes	No
Visual Impairment (cataracts, glaucoma, macular degeneration)	Yes	No	Liver/Gallbladder	Yes	No
Metal Implants	Yes	No	Nausea/Vomiting	Yes	No
Pacemaker/Defibulator	Yes	No	Pregnancy	Yes	No

Are you on medication?:_____

☐Check here is given to staff to be scanned to chart

To better understand your pain, please circle all that apply:

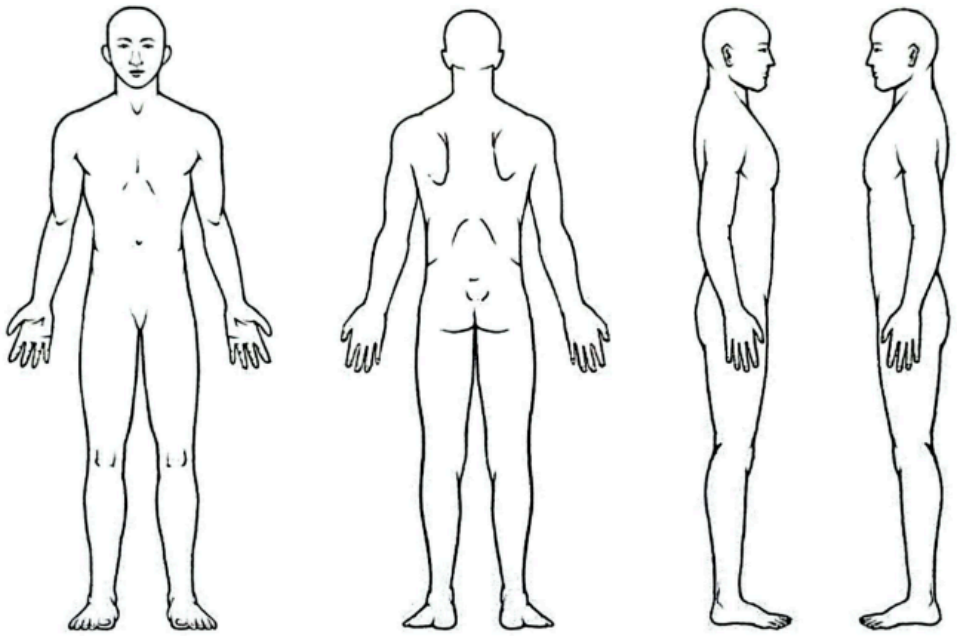
My pain is worse: in the morning/ during the day/ at night/ constant/with activity/during rest

On a scale of 0-10 (0 being no pain and 10 requiring hospitalization)

Please Rate your pain at its best:_____ and at its worst:_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain

Is there any information regarding your medical history we should know?

_____

What are your goals for therapy at this time?

_____

Financial Agreement

Dear Valued Patients,

At Advantage Therapy and Rehabilitation, we strive to provide you with the highest quality care while ensuring a flexible and convenient payment process. To continue delivering exceptional services, we are updating our billing and payment policy, effective January 2025.

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

Payment Plan for Deductibles and Coinsurance:

- **IF your deductible is NOT met we will collect 50 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/visit 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.

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, Provana .

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

Sincerely,
Advantage Therapy and Rehabilitation.

Please sign below to agree to the financial agreement.

Patient or POA:_____

Date: _____

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 to receive it in writing. 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:

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: _____