For Office Use Only:

Account #: ___________________

Therapist: ___________________

Insurance: ___________________

PATIENT INFORMATION – Please **print** and complete all fields.

Name: ____ Preferred/Nickname: __________________
Last First MI

Address: ____
PO Box/Street City State Zip Code

Home #: _________________________ Work #: _________________________ Cell #: __________________________

DOB: _____/_____/_____ SSN: ______-_____-______ Sex: M F Marital Status: M S W D Life Partner

Employer: ______________________________________ Address: ____

Email Address: ____ (for internal use only)

REFERRAL INFORMATION

Referring Physician: _______________________________ Primary Care Physician: __________________________________

Would you like for us to release a copy of your evaluation to your Primary Care Physician? Yes No

How did you hear about Advantage Therapy? ____

REASON FOR YOUR VISIT

Chief Complaint: ____

Accident? Y N Description of Accident: ________________________________ Date: ____/____/____ Time: ________

Accident Type: ____ Work Comp ____ Auto Other: ____

Do you have a work comp case manager/rehab nurse following your care?

Name: _____________________________________ Company: ________________ Phone #: _______________________

EMERGENCY CONTACT

Name: ____________________________ Relationship: ____________ DOB: ____/____/____ Phone #:______________

PRIMARY INSURED OR RESPONSIBLE PARTY (IF MINOR)

Name:____ DOB: ____/____/____ SSN: ______-______-_______

Address: ____ Relationship to Patient: ________________________

Ph #: _______________________ Employer: ____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I verify that all information is correct to the best of my knowledge. I authorize Advantage Therapy to release any of my medical information necessary to process claims. I allow a copy of this authorization to be used in place of the original.

Signature: ____ **Date:** ______/______/_____

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advantagetherapyonline.com

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Advantage Therapy to furnish medical care and treatment to _______________________ which is considered necessary and proper in diagnosing or treating his/her physical and medical condition.

ASSIGNMENT OF BENEFIT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to Advantage Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Advantage Therapy to release all information necessary, including medical records to secure payment.

FINANCIAL POLICY STATEMENT

You are responsible for the entire balance of your bill. We shall bill your insurance carrier solely as a courtesy to you. We require that arrangements for payment of your estimated share be made today. If you insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services rendered by us, you recognize an obligation to promptly remit the same to Advantage Therapy.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ ____________________

Responsible Party/Parent/Guardian Date

____ ____________________

Center Representative Date

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PRIVACY NOTICE

I received / declined a copy of Advantage Therapy's Notice of Privacy Practices.

Copy of policy available at front desk upon request.

____ ____________________

Patient/Parent/Guardian Date

____ ____________________

Center Representative Date

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KEEPING YOUR APPOINTMENTS AT ADVANTAGE THERAPY

We are here to help you achieve your goals and return to work and to the life that you want. We will do our part to the best of our ability to help you improve. You will get the most out of your time in therapy by fully participating in your treatment… that means attending your appointments and doing your home exercises.

We do understand things can happen that may be out of your control that could interfere with your appointment times such as illness or emergency. In the event this happens, please contact us so that we are able to make your appointment time available to another client.

For clients who are being treated for a work-related injury under Workers' Compensation, please note:

- If you cancel your appointment without rescheduling or fail to attend a scheduled appointment without notifying our office, resulting in fewer weekly visits than assigned by your physician, please be aware that your doctor, employer, and nurse case manager or adjuster will be notified.

We look forward to working with you to reach your goals and appreciate your cooperation.

_______________________________________ ____________________

Patient/Parent/Guardian Date

_______________________________________ ____________________

Center Representative Date

At Advantage Therapy, our goal is to provide you with the most complete, personalized care. In order to do so, we ask that you fill out this medical history questionnaire.

Current Condition Overview

Current medical problem/reason for today's visit: ____________________

Date of onset for this injury/condition: ____________ Have you had imaging? ☐ None ☐ MRI ☐ X-ray ☐ CT scan

Please list imaging results: ____________________

Have you had surgery for this? ☐ Yes ☐ No If applicable, date and type of surgery: ____________

Please list all past surgeries: ____________________

Have you had previous PT or OT for this? ☐ Yes ☐ No Where? ____________

Do you have a history of any of the following?

High Blood Pressure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Angina/Chest Pain	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Latex allergy?	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	List any allergies:	
Stroke	☐ Yes ☐ No	Hepatitis/HIV	☐ Yes ☐ No	____________	
Kidney Disease	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	____________	
Diabetes	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	____________	

In the past 3 months, have you experienced any of the following?

Change in your health	☐ Yes	☐ No	Nausea/vomiting	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Urinary Tract Infection	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Upper Respiratory Infection	☐ Yes	☐ No
Fever/chills/sweats	☐ Yes	☐ No	Unexplained weight change	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No	Change in appetite	☐ Yes	☐ No
Weakness	☐ Yes	☐ No	Change in bowel/bladder	☐ Yes	☐ No

If you answered "yes", please describe: ____________________

Are you currently pregnant? ☐ Yes ☐ No Do you drink alcohol regularly? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No If yes, _____ packs per day for _____ years. Last tobacco use: ________

Have you had 2 or more falls in the past year, or any fall with injury in the past year? ☐ Yes ☐ No

Weight: ________ Height: ________ Calculated BMI (to be completed by therapist; for internal use only): ________

Please answer the following questions regarding your current condition:

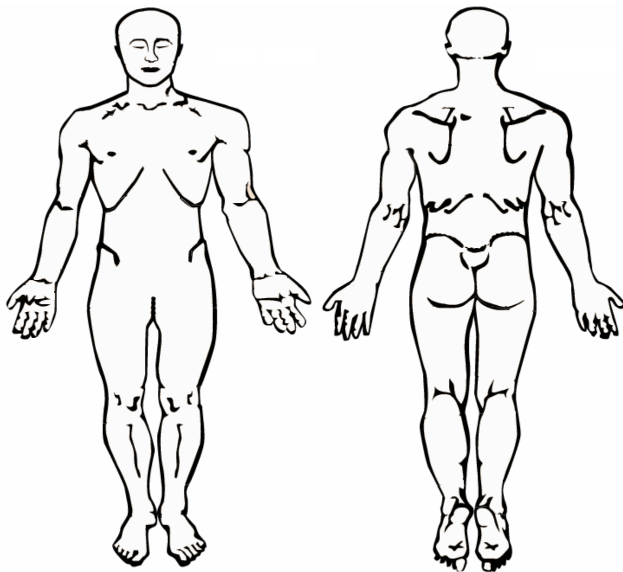
My symptoms are:	☐ Getting worse	☐ Staying the same	☐ Getting better
How are you able to sleep at night?	☐ Fine	☐ Moderate difficulty	☐ Only with medication

I currently have difficulty with the following daily activities as a result of my current condition:

- ☐ Standing/Walking
- ☐ Sitting
- ☐ Getting up from a chair
- ☐ Driving
- ☐ Bending/Lifting
- ☐ Sleeping
- ☐ Dressing/Grooming
- ☐ Grasping
- ☐ Reaching overhead
- ☐ Reaching behind back
- ☐ Work activities
- ☐ Other: ______________________________

Use the following drawing & symbols shown to indicate the location and type of symptoms you are experiencing:

SHARP PAIN	ACHINESS	BURNING	NUMBNESS
////////	XXXXX	OOOOO	+++++



Circle your pain on the 0-10 scale below. 0 is considered no pain and 10 is considered the worst pain imaginable.

Your pain now:

0------1------2------3------4------5------6------7------8------9------10

Your pain at its worst:

0------1------2------3------4------5------6------7------8------9------10

Your pain at its best:

0------1------2------3------4------5------6------7------8------9------10

How would you rate your stress level? 0------1------2------3------4------5------6------7------8------9------10

Please list all medications, vitamins, and supplements you are currently taking. Please circle the method, list the dosage and circle the frequency by which you take them. If you brought in your medications list today, we will gladly copy it.

Medications, Vitamins, Supplements	Method (circle one)	Dosage	Frequency (circle one)
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day
	Oral Patch Inhaler Injection		1x/day 2x/day 3x/day

Patient Signature: ______________________ Date: ______________

Therapist Signature: ______________________ Date: ______________