



NEW CLIENT INFORMATION

LOCATION: 7844 Green Meadows Drive Lewis Center, OH 43035

PHONE: 740-549-7041

Welcome to Athletic Advantage Physical Therapy!

To learn more visit our website: www.PTadvantage.com

You can also find us on Facebook and Instagram @AAPTOhio

Please complete the applicable forms on the following pages and bring them with you at the time of your appointment.

Bring your insurance card(s) and ID. Also bring your physical therapy referral or prescription from your medical doctor, if applicable. For workers compensation claims, bring your BWC and MCO cards and a C-9 authorization from your medical doctor on record. For auto accidents, details are required to be provided to our staff prior to scheduling your first appointment.

Wear comfortable loose fitting sportswear to your appointments.

Thank you and we look forward to meeting you!

Mark Read, PT, Meghan Kemper, PT, PhD
Fauzia Asad, PT, CLT-LANA

Shannon Quick, CMM, HITCM-PP, Cert. NatMed, Cert. Sound Therapist
Clair Hollback, Marketing Communications Manager



PATIENT INFORMATION COLLECTION FORM

Patient Name _____ Birth date _____ Age _____ Male ___ Female ___

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____ Marital Status: Single ___ Married ___ Other ___

SSN _____ Email address: _____

Spouse or parent's name (as applicable) _____ Phone Number () _____

Employer / School Name _____ Address _____

Emergency Contact _____ Phone () _____ Referred by _____

Your Physician's name(s) _____ Phone () _____

Address _____

I understand that AAPT will use the above address and/or phone numbers to contact me and leave messages if necessary regarding: scheduling appointments, appointment reminders and other information.
 Yes you may contact me No, please use alternate method
Alternate method of contact _____
Initials of Patient/Legal Representative _____

GUARANTOR INFORMATION (Person responsible for paying for this appointment) Write "same as patient" if patient is Guarantor.

Name _____ Relationship to patient _____ Home Phone () _____

Address _____ City _____ State _____ Zip _____ Other Phone () _____

Social Security Number _____ Date of Birth _____

Guarantor's Place of Employment _____ Employer Phone _____ Insurance? Y/N

Guarantor's Employer Address _____ City _____ State _____ Zip _____

Insured's (Subscriber) Information (Person carrying insurance on this patient)

Name _____ Relationship to patient _____ Home Phone () _____

Address _____ City _____ State _____ Zip _____

Subscriber's Place of Employment _____ Phone # () _____

Subscriber's Employer Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____

INSURANCE _____ Insurance ID Number _____ Insurance Group Number _____

LATE CANCELLATION AND MISSED APPOINTMENT POLICY

I understand that the following fees may be charged for the stated reasons:

- There is a **\$45 fee** charged to clients who fail to cancel their appointments without giving Athletic Advantage a business day 24-hour notice, and if we are unable to schedule another patient in that appointment time.
- There is a **\$65 fee** charged to clients who simply fail to arrive for their scheduled appointments without any notice whatsoever.

Signature _____ Printed Name: _____ Date _____



HIPAA Privacy Authorization Form

Effective Date: 01/01/2026

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

- 1. **Authorization.** I authorize *Athletic Advantage, Inc* to use and disclose the protected health information described below to a business entity known as _____ (Your Insurance Company(s))
- 2. **Effective Period.** This authorization for release of information covers all treatment for this episode of health care.
- 3. **Extent of Authorization.** I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
- 4. **Use.** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- 5. **Termination.** This authorization shall be in force and effect until the date of 12/31/2026, at which time this authorization form expires.
- 6. **Revocation Rights.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- 7. **Benefits.** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- 8. **Disclosure.** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

9. Designated Individuals Authorization (Optional)

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____ Name: _____ Relationship: _____

I have read and understood the above consents, assignments of benefits, release of information, and designated individuals' authorization above.

Patient's Signature (or Personal Representative) Patient's (or Parent/Guardian) Printed name Date: _____

Insurance Questionnaire

- 1. Have you had Physical, Occupational, Respiratory, Speech-Language or Cardio-Pulmonary Therapy this benefit year? **YES NO**
If Yes, How many visits? _____ If your insurance has a limited number of Visits allowed per year, we may need to account for these.
- 2. Is the condition for which you are currently seeking treatment a result of a liability claim? (i.e. Worker's Compensation, Auto accident, personal liability) **YES NO**

How did you find us?

- Referral/Word of Mouth
- Google/Internet Search
- Facebook/Social Media
- Flyer/Mailer/Print Advertisement
- Other



Financial Policy

Your clear understanding of our financial policy is important to our professional relationship. Most insurance policies specify that some of the cost of the patient’s case is the patient’s responsibility. Payment of co-payments, co-insurance and deductibles are required at the time of service. We accept Visa, Mastercard, personal check or cash. While the filing of insurance claims in a courtesy that we extend to our clients, all charges are your responsibility from the date that the services are rendered. In order for us to file a claim, you must present a current copy of your insurance case and communicate any changes in your personal contact information.

Your health coverage is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize that as a healthcare provider, our relationship is with you, not with your insurance company.

Before your first appointment at Athletic Advantage, please contact your insurance company to verify that we are an in-network provider with your plan and that the services you intend to receive are covered. Our Tax ID number is 31-1298605. In addition, some insurance plans require either pre-authorization and/ or a doctor’s referral before you can be seen. Not all services are a covered benefit in all plans so it is important that you understand the provisions of your policy

Patient's Signature (or Personal Representative) Patient's (or Parent/Guardian) Printed name Date: _____

Direct Access

Under Direct Access Law in Ohio, I am requesting an evaluation and treatment for current injuries and or pain complaints. It is my choice whether to obtain a referral from my physician or to seek rehabilitative treatment independently. In either case, I believe it is in my best interest to pursue treatment. My health insurance company may request proof of medical necessity. If this becomes necessary, I understand my responsibility to obtain proof of medical necessity from my primary care physician or another medical doctor.

Patient's Signature (or Personal Representative) Patient's (or Parent/Guardian) Printed name Date: _____

Consent to be Treated

I hereby consent to the assessment and treatment of my conditions by a licensed physical therapist employed by Athletic Advantage, Inc. The Physical Therapist will explain the nature, purpose, and findings of this assessment, and possible course of treatment. The Physical Therapist will inform me of expected benefits and/or complications as well as alternatives to the proposed treatment and risk and consequences of no treatment. I have provided the Physical Therapist with a thorough medical history prior to being assessed.

Patient's Signature (or Personal Representative) Patient's (or Parent/Guardian) Printed name Date: _____

Medicare Patients only

For CY 2026, the KX modifier threshold amounts are \$2480 for Physical Therapy and Speech-Language Pathology services combined. Medicare updated the annual per-beneficiary incurred expenses amounts now called KX modifier thresholds and related policy for Calendar Year 2026. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as “therapy caps” before the Bipartisan Budget Act of 2018 was signed into law repealing the application for the caps. Medicare covers **80%** of eligible expenses after a **\$283.00 Part B deductible**.

In order to properly bill Medicare we need to know the following information:

- 1. Have you received Physical Therapy or Speech-Language Therapy (Part B Services) at any point during this calendar year?
Please circle: **Yes** **No** How Many Visits? _____
- 2. Is the condition you are seeking treatment for a result of a work related injury or illness? **Yes** **No**
- 3. Are you currently employed and have health insurance through your employer? **Yes** **No**

I authorize release of medical information to be sent to Medicare and my MediGap Insurance _____ which is necessary to process the claim. I also authorize payment of benefits to Athletic Advantage, Inc., an authorized supplier of Medicare services.

Date: _____



HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

Do you have history of any of following:

- | | |
|------------------------------------|---|
| _____ Heart Condition _____ | _____ Skin Conditions |
| _____ High Blood Pressure | _____ Blood Born illness (HIV, Hep A/B/C, TB) |
| _____ Pacemaker | _____ Cancer: Area Affected _____ |
| _____ Diabetes | _____ Anxiety/ Depression/Panic Disorders |
| _____ Cancer: Area Affected _____ | _____ Pain at night |
| _____ Pregnancy | _____ Osteoporosis/ Osteopenia |
| _____ Neurological disorders _____ | _____ Other _____ |
| _____ Are you Pregnant? | |

SURGICAL AND INJURY HISTORY

Please list all surgeries and injuries below and when they occurred (approximate)

_____ Date: _____	_____ Date: _____
_____ Date: _____	_____ Date: _____
_____ Date: _____	_____ Date: _____

MEDICATIONS

Please list any current Medications/Supplements that you are currently taking

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your reason for coming to therapy today? _____

When did your problem begin? _____

How did your problem start? _____

Are you allergic to adhesives/tape, latex, or bee stings? **Yes No** If Yes, please list _____

Have you had physical therapy previously for the same problem? **Yes No**

Are you receiving other treatments for this problem at this time? **Yes No** If yes, please list: _____

What kind of tests have been done for your **current** problem? (check if applicable) **MRI X-Ray CT Scan Myelogram**

Or List: _____ **Results:** _____

Have you been hospitalized in the past year **for this condition**? **Yes No** If yes, when and for how long?: _____

Patient Name: _____ Date: _____

PAIN

Do you have pain now? No Yes, Location/Type: _____

What makes it better? _____

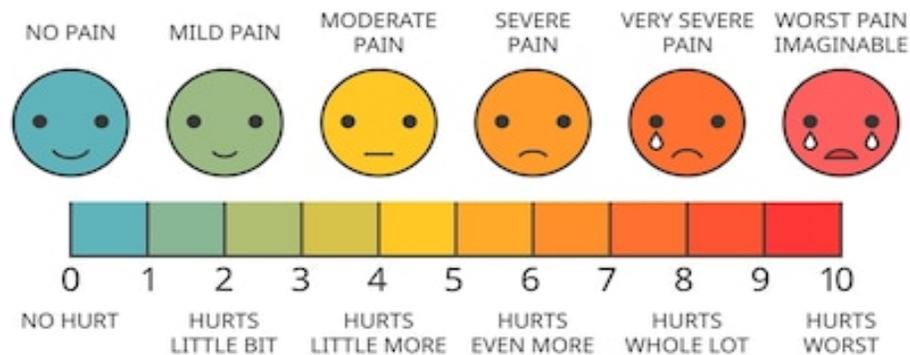
What makes it worse? _____

Does the pain interfere with your daily life? **No** **Yes**, Describe: _____

RATE YOUR PAIN ON A SCALE OF 0-10 (0 BEING NO PAIN AND 10 BEING THE WORST) ____/10 Today

(see scale below)

PAIN MEASUREMENT SCALE



Type of Pain: **Constant** **Intermittent** **Shooting** **Dull** **Sharp Ache**

Pain relieved by: **Heat** **Ice** **Rest** **Medication** **Movement**

BALANCE:

1. Have you fallen in the last 6 months? **Yes** **No** How many times? _____

2. Have you had a decrease in your activity level because of a fear of falling? **Yes** **No**

3. Are you reluctant to leave your home because of a fear of falling? **Yes** **No**

What are your goals as a result of attending physical therapy?

Please check appropriate box.

- | | |
|---|---|
| <input type="checkbox"/> Decrease pain | <input type="checkbox"/> Improve strength |
| <input type="checkbox"/> Less difficulty with work activities | <input type="checkbox"/> Stand longer ____ minutes / hours. |
| <input type="checkbox"/> Sleep longer _____ hours | <input type="checkbox"/> Sit longer ____ minutes / hours. |
| <input type="checkbox"/> Improve movement | <input type="checkbox"/> Less difficulty with home activities |
| <input type="checkbox"/> Return to recreational activities / sports | |

Anything else: _____



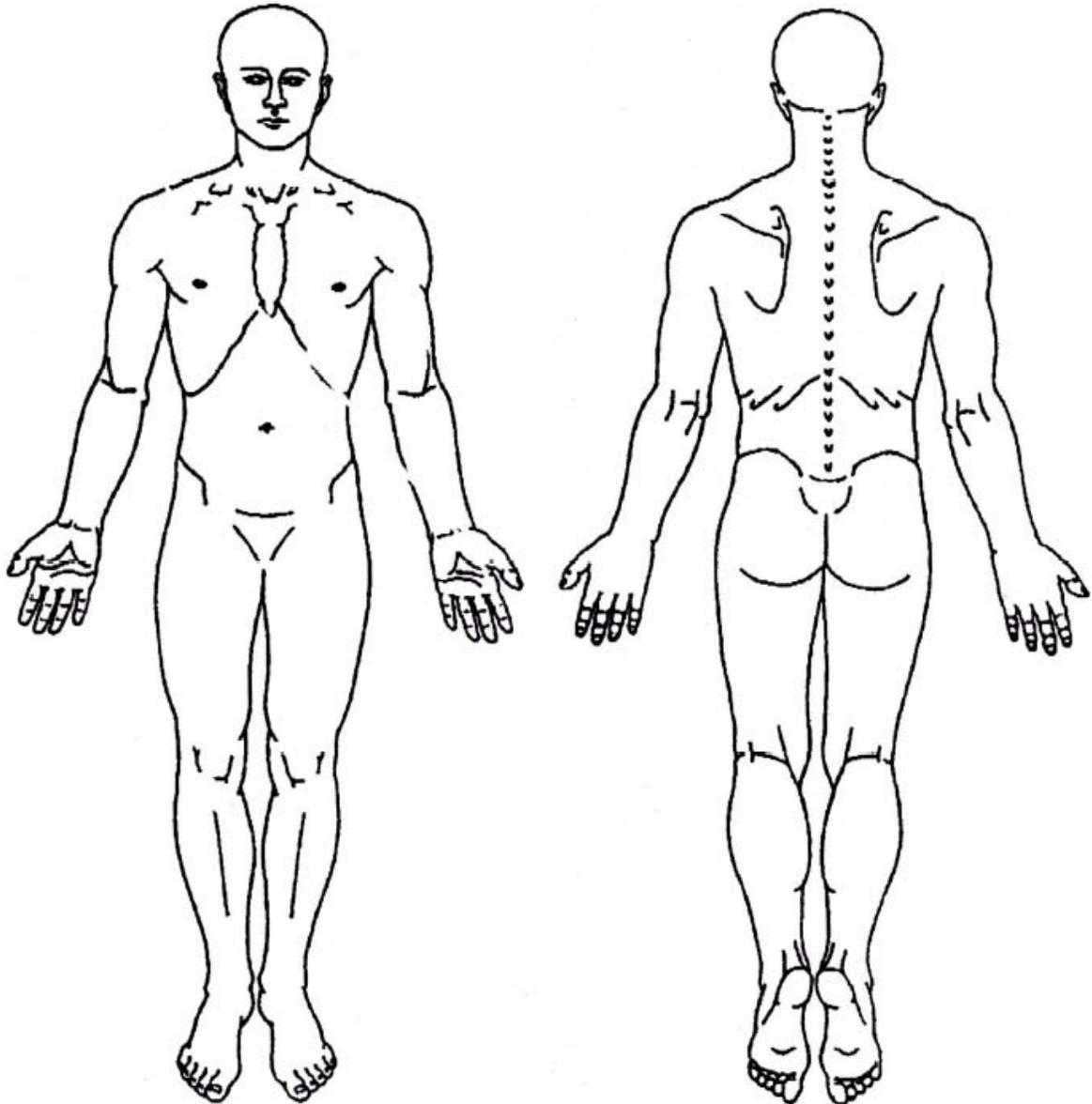
ATHLETIC ADVANTAGE PHYSICAL THERAPY

A Myofascial Release and Wellness Center

Prevention • Education • Rehabilitation

NAME _____ DATE _____

PLEASE SHADE IN AREAS OF PAIN and/or SYMPTOMS



If you are interested in a Complimentary consultation for Vibrational Sound Therapy, please complete this form.



Vibrational Sound Therapy Intake Form

Full Name: _____ DOB: _____

Email: _____

Current Methods of relaxation: _____

What are the main stressors in your life? _____

Have you ever had a sound therapy session? **Yes No** Do you have any sensitivity to vibration or sound? **Yes No**

Do you have difficulty laying on your front or back? **Yes No**

Please list any surgeries or injuries in the last 2 years: _____

Do you have any metal implants, pacemaker, or piercings? _____

Please list health history or medications (i.e. heart, blood pressure, anxiety, numbness, tingling, pregnancy, epilepsy, seizures etc) _____

Please rate your stress level **1- 10** (10 being highest) _____

Please rate your pain level **1- 10** (10 being highest) _____

Please rate your anxiety level **1- 10** (10 being highest) _____

Do you have any allergies or sensitivities to essential oils, incense or sage (ceremonial)?

I hereby consent to receive on the body sound work. I understand the practitioner will be using gentle vibration and sound during this session on and around me. I have completed this form to the best of my ability. I acknowledge that these sessions are not a substitute for medical examination or diagnosis. I understand that these sessions are for relaxation and self-care.
