ATHLETIC ADVANTAGE
PHYSICAL THERAPY
A Myofascial Release and Wellness Center

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

ATHLETIC ADVANTAGE
PHYS CA_ THERAPY

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.

_____ _____ Date: _____

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

Insurance Questionnaire

1. Have you had Physical, Occupational, Respiratory, Speech-Language or Cardio-Pulminary 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 heath 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

_____ _____ Date: _____

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

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.

_____ _____ Date: _____

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

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.

_____ _____ Date: _____

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

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: _____

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

ATHLETIC ADVANTAGE PHYSICAL THERAPY

HEALTH QUESTIONAIRRE

Patient Name: _____ Date: _____

Do you have history of any of following:

_____ Heart Condition_____
_____ High Blood Pressure
_____ Pacemaker
_____ Diabetes
_____ Cancer: Area Affected_____
_____ Pregnancy
_____ Neurological disorders_____
_____ Are you Pregnant?

_____ Skin Conditions
_____ Blood Born illness (HIV, Hep A/B/C, TB)
_____ Cancer: Area Affected_____
_____ Anxiety/ Depression/Panic Disorders
_____ Pain at night
_____ Osteoporosis/ Osteopenia
_____ Other_____

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: _____

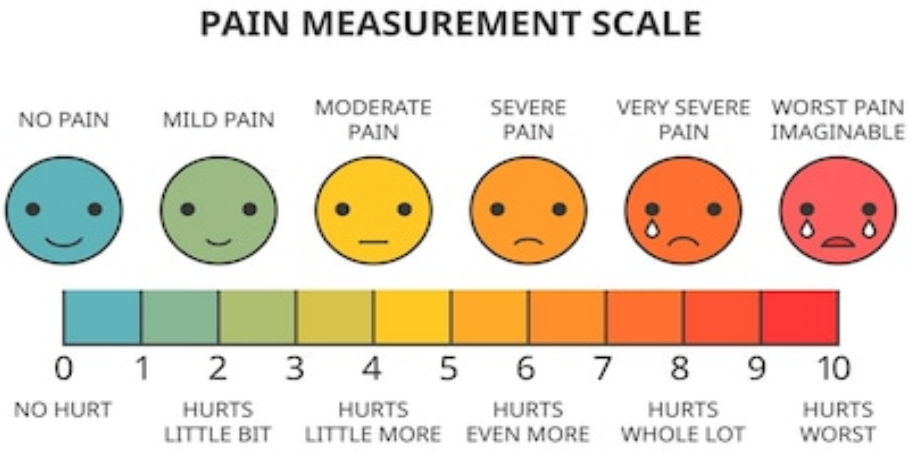
What makes it better? _____

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)



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.

- ☐ Decrease pain
- ☐ Less difficulty with work activities
- ☐ Sleep longer _____ hours
- ☐ Improve movement
- ☐ Return to recreational activities / sports
- ☐ Improve strength
- ☐ Stand longer ___ minutes / hours.
- ☐ Sit longer ___ minutes / hours.
- ☐ Less difficulty with home activities

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