

# **ATHLETIC ADVANTAGE PHYSICAL THERAPY, INC.**

## **New Client Information**

**Location: 8849 Whitney Drive, Lewis Center Ohio 43035      phone: 740.549.7041**

**Welcome to Athletic Advantage Physical Therapy!  
Visit our website [www.ptadvantage.com](http://www.ptadvantage.com)**

**Please complete these forms and return them to us at the time of your appointment.**

Also, please bring your physical therapy referral/Rx from your physician if applicable, your driver's license and insurance card(s). For Workers Compensation claims, bring your BWC and MCO cards and a C-9 authorization from your doctor on record.

For auto accidents, please provide your attorney's info if applicable, proof of auto insurance certificate and driver's license.

We recommend that you wear comfortable loose fitting sportswear to your appointment.

- ***There is a \$45 fee charged to clients who fail to give 24 hours notice of a cancellation and if we are unsuccessful to schedule another patient.***
- ***There is a \$65 fee charged to clients who fail to show up for an appointment and do not call to give advance notice.***

Thank you!

We look forward to serving you,

***Mark Read, LPT***

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Other Phone \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Birth date \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Other \_\_\_

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

Address if different from above \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address: \_\_\_\_\_

Employer / School Name \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Referred by \_\_\_\_\_

Is this visit related to: Your employment? (work injury) Y / N Auto Accident? Y / N Sports? Y / N

If other reasons please explain:

\_\_\_\_\_

Your Physician's name \_\_\_\_\_ Date accident/injury occurred? \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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 \_\_\_\_\_ INSURANCE \_\_\_\_\_

Subscriber's Place of Employment \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Insurance Group Number \_\_\_\_\_ Insurance ID Number \_\_\_\_\_

Subscriber's Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

If Spouse's insurance is applicable, Spouse's name \_\_\_\_\_ Insurance & Group Number \_\_\_\_\_

Spouse's Place of Employment \_\_\_\_\_ Employer Phone Number ( ) \_\_\_\_\_

Spouse's Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**There is a fee for NO-SHOWS and CANCELLATIONS received less than 24 hours prior to your scheduled appointment**

Athletic Advantage Physical Therapy, Inc.  
8849 Whitney Drive  
Lewis Center, OH 43035  
Phone# 1-740-549-7041  
Fax# 1-740-549-7045

**CONSENT TO BE TREATED**

Under direct access law in the state of Ohio I am requesting an evaluation and treatment for current injuries and or pain complaints.

It is my choice whether to obtain a prescription from my physician or to seek rehabilitative treatment independently. In either case, I believe it is in my best interest to pursue treatment. My insurance carrier may request proof of medical necessity. If this becomes necessary, I understand my responsibility to obtain proof of medical necessity from my primary care or family physician or another medical doctor. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

I direct my insurer, attorney or third party administrator to directly pay without equivocation AAPT all the benefits due them. I am aware that I am personally responsible for all charges by AAPT. This may include but is not limited to medical insurance, auto insurance, third party liability claims and workers compensation if the BWC claim is denied. If my account is turned over to a collection agency or attorney, I am responsible for those additional fees added to my balance. If I receive any payment or Explanation of Benefits (EOB) from my insurance carrier, I will immediately give them to AAPT.

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**I have read all the above information and understand it.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**I acknowledge I have read Athletic Advantage Privacy Notice.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT MEDICAL INFORMATION

NAME: \_\_\_\_\_ today's DATE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR TODAY? \_\_\_\_\_

HOW DID THIS OCCUR? \_\_\_\_\_

LIST ANY MEDICATION ALLERGIES OR TYPES OF REACTIONS YOU MAY HAVE.  
(Allergies to band-aids, tape, heat, ice, latex, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Have you **recently** had any of the following: If yes, please give a brief description:

\_\_\_\_\_ X-Rays \_\_\_\_\_

\_\_\_\_\_ E.M.G. \_\_\_\_\_

\_\_\_\_\_ Surgery \_\_\_\_\_

Do have a history of any of the following:

\_\_\_\_\_ Heart Condition

\_\_\_\_\_ Pregnancy

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Skin Conditions

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Cancer: area affected \_\_\_\_\_

\_\_\_\_\_ Pace Maker

\_\_\_\_\_ Pain Pump

\_\_\_\_\_ Spinal Cord Stimulator

\_\_\_\_\_ Other \_\_\_\_\_

**Please circle the following:**

Your rate of pain today: 0 1 2 3 4 5 6 7 8 9 10  
No Pain Extreme Pain

Type of Pain: Constant Intermittent Shooting Dull Sharp Ache

Pain relieved by: Heat Ice Rest Medication Movement

Injury Occurrence: Sudden Chronic (over a period of time)

## DIRECTIONS TO ATHLETIC ADVANTAGE

### From 270:

Exit Route 23 North towards Delaware.

Turn right onto E Powell Rd (Rt 750 East) at the Nationwide Ins building.

Drive *past* the stop-light at Green Meadows Dr then immediately turn left onto Cotter St to enter the Green Meadows Commerce Center.

Stay left to pass the pond and turn right onto Carle Ave.

Drive to the end of Carle Ave (at the STOP sign) and turn right onto Whitney Drive. Our clinic is located on your left at 8849 Whitney Drive.

### From 315 traveling northbound:

Exit 270 East, and follow directions above (from I-270)

### From 71 traveling northbound:

Exit and turn left onto Gemini Parkway.

At the Polaris Parkway intersection, turn right.

(Polaris Pkwy will become E. Powell Road at the Old State Road intersection, continue straight)

Immediately after the RR overpass, turn right at the first street, onto Cotter Street to enter the Green Meadows Commerce Center.

Stay left to pass the pond and turn right onto Carle Ave.

Drive to the end of Carle Ave (at the STOP sign) and turn right onto Whitney Drive. Our clinic is located on your left at 8849 Whitney Drive.

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8849 Whitney Drive

Lewis Center, OH 43035

740-549-7041

## ATTENTION PATIENTS AND POLICY HOLDERS:

DUE TO THE CONSTANT CHANGES IN INSURANCE POLICIES PLEASE BE AWARE THAT IT IS YOUR RESPONSIBILITY TO KNOW YOUR HEALTH INSURANCE BENEFITS ON YOUR OWN PLAN. CONTACT YOUR HEALTH INSURANCE PROVIDER PRIOR TO YOUR APOINTMENT AND CHECK YOUR PHYSICAL THERAPY BENEFITS. VERIFY THAT WE ARE A COVERED PROVIDER ON YOUR PLAN. OUR TAX ID NUMBER IS 31-1298605.

### GENERAL QUESTIONS TO ASK:

- DO YOU HAVE A CO-PAY or CO-INSURANCE LIBILITY FOR EACH VISIT?
- DO YOU HAVE A DEDUCTIBLE TO SATISFY BEFORE BENEFITS ARE AVAILABLE?
- WHAT IS THE ALLOWED NUMBER OF VISITS PER YEAR FOR YOUR PLAN?
- IS AUTHORIZATION OR REFERRALS NEEDED FOR PHYSICAL THERAPY?
- WHAT IS THE EFFECTIVE DATE OF YOUR POLICY?

FAILURE TO COMPLY MAY RESULT IN NON-PAYMENT FROM YOUR INSURANCE COMPANY AND YOU WILL THEN BE RESPONSIBLE FOR ANY UNPAID CLAIMS.

IF YOU HAVE ANY QUESTIONS WE WILL BE MOST HAPPY TO ASSIST YOU!