ATHLETES ADVANTAGE

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____

State: _____ Zip: _____ ○ M ○ F Email: _____

Home #: _____ Work #: _____ Cell #: _____

Date of Birth: ____/____/_____ SSN: _____ ○ Single ○ Married ○ Divorced ○ Widowed

Emergency Contact: _____

Phone #: _____ Relationship: _____

Responsible party for bill if other than patient: _____

Address: _____

Date of Birth: ____/____/_____ SSN: _____ Relationship: _____

How did you hear about Athletes Advantage? _____

MEDICAL

Primary Care Physician/Family Doctor(s): _____

Are you currently under the care of a Home Health Agency? ○ No ○ Yes

If yes, the company's name is: _____

Have you had any physical, occupational, or speech therapy this year? ○ No ○ Yes

CONSENT

I hereby consent to receive care for physical therapy services by Athletes Advantage. I consent to medical treatment as is deemed necessary or advisable by the physical therapist. I authorize Athletes Advantage to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself and physician(s). I authorize Athletes Advantage to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

I understand that Athletes Advantage does not contract with any insurance providers for the provision of physical therapy services.

I hereby certify that I understand these rights as set forth.

I acknowledge that I have been informed of Athletes Advantage's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPPA).

I have been presented with a brochure outlining these practices. ○ No ○ Yes

I have received a copy of the Summary of the Florida Patient's Bill of Rights and Responsibilities. ○ No ○ Yes

Patient/Responsible Party Signature: _____ Date: _____

Legal Representation (if applicable): Attorney's Name _____

Parent signature if Minor: _____

please continue on reverse side

HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Describe your current complaint/limitation: _____

Describe how your problem began: _____

Indicate when your condition began: _____

List tests/other interventions for your condition: _____

Indicate daily activities you cannot perform: _____

Indicate the level of function prior to the onset of your condition: _____

Inform us of any environmental or living conditions you may have difficulties with: _____

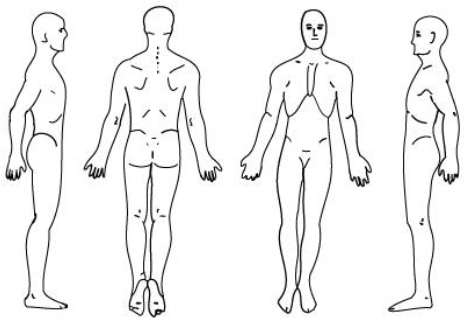
Did you have surgery? ○ No ○ Yes Date: _____ Procedure: _____

PLEASE DESCRIBE THE NATURE OF YOUR PAIN:

○ Sharp Pain
○ Dull (Pain) Ache
○ Throbbing
○ Numbness
○ Shooting
○ Burning
○ Tingling

○ Constant (76 – 100%)
○ Frequent (51 – 75%)
○ Occasional (26 – 50%)
○ Intermittent (25% or less)

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS → → →



Indicate the intensity of your pain at rest: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: ○ Decreased ○ Not Changed ○ Increased

Your Symptoms are worse in: ○ Morning ○ Afternoon ○ Night ○ Increased during the day ○ Same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation: _____ Has your work status changed because of this condition? ○ No ○ Yes

PAST & PRESENT CONDITIONS

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
○	○	High Blood Pressure
○	○	Angina
○	○	Heart Attack
○	○	Stroke
○	○	Asthma
○	○	HIV/AIDS
○	○	Cancer (Location: _____ Date: _____)
○	○	Tumor
○	○	Systemic Lupus
○	○	Hepatitis
○	○	Epilepsy
○	○	Diabetes
○	○	Rheumatoid Arthritis
○	○	Arthritis
○	○	Pregnancy
○	○	Other
○	○	Tobacco (Packs Per Day: _____)
○	○	Drug/Alcohol Dependence

Hospitalization/Surgical Procedures *(list if not described elsewhere)*:

_____

_____

_____

Do you have a Pace Maker? ○ No ○ Yes

Medications *(Specify name, dosage, frequency & route of administration)*:

_____

_____

_____

_____

Weight: _____ Height: _____ft _____in

CREDIT CARD AUTHORIZATION (OPTIONAL)

Credit Card Information

Name (as seen on card): _____

Billing Address: _____

City: _____ State: _____ Zip: _____ Email Receipt: ○ No ○ Yes

Email: _____

Credit Card Type: ○ MasterCard ○ Visa ○ Discover ○ American Express

Credit Card #: _____

Security Code: _____ Expiration Date: _____

I authorize Athletes Advantage, LLC to initiate a recurring charge to the credit card indicated above for the total amount due each week. I also authorize charges for any additional related services that I may incur. Charges to my account may vary. I will be provided notice if the charges exceed $_____.

I understand that I may cancel my recurring charge upon written notice to Athletes Advantage allowing up to a thirty days time for action on my cancellation notice.

Card Holder's Signature: _____ Date: _____

Late Cancel Policy: Clients are subject to a 50% session charge for cancelling with less than a 24-hour notice.
No-Show Policy: Clients are subject to a 100% session charge for no-showing without notice.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
A patient has the right to a prompt and reasonable response to questions and requests.
A patient has the right to know who is providing medical services and who is responsible for his or her care.
A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

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Part of your recovery may include the use of our gym as well as a transition into fitness training.
The following waivers outline our Gym Rules and Release and Hold Harmless Agreement.

GYM RULES

- Gym members ONLY have access to the weight room & cardio equipment. Use of any other areas, including but not limited to the rehab clinic, the red floor or turf, MUST be approved by a staff member.
- Return all weights and any other equipment used to its proper location.
- DO NOT DROP weights on the floor.
- Do not move equipment.
- Do not use offensive language.
- Be respectful of other clients and staff.
- Bring a towel to wipe equipment.
- Collars MUST be used on all bars at all time.
- DO NOT ADJUST TVs or fans.
- No chewing gum is allowed in the facility.
- No drinks with the exception of water is allowed on turf areas.

I understand that failure to adhere to the rules above will result in the termination of my gym membership without refund.

Print Name: _____ Date: _____

Signature: _____ Staff Initial: _____

RELEASE & HOLD HARMLESS AGREEMENT

Know all persons by these presents that _____ individually in consideration for the participation in all activities at Athletes Advantage located at 11120 S. Crown Way, Suite 5, Wellington, Florida 33414 and other good and valuable consideration does hereby release, acquit and forever discharge and, except as otherwise reversed below, their heirs, executors, administrators, successors, assigns, affiliates, employees, insures, agents, and representatives of and from any and all claims, damages, demands, actions, causes of action, alleged or brought, or which could have been alleged or brought under the law, codes and statues of any and all states, federal, foreign, local or territorial jurisdictions, of whatever name or nature in any manner arising, arising from, arising or to grow out of any and all accidents, incidents, occurrences or matters, through the alleged negligence and/or wrongful acts of Athletes Advantage, LLC.

This RELEASE OF ALL CLAIMS includes among other things, but is not limited to, any and all claims, damages, demands, actions causes of action, alleged or brought, or which could have been alleged or brought, of whatever name or nature made by Athletes Advantage, LLC on our individual and collective capacities, or anyone on our behalf, against which have arisen or may arise out of the use of Athletes Advantage's facility, specifically including but not limited to, any and all claims for bodily injury and any and all resulting pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life experienced in the past or to be experienced in the future, any aggravation of an existing disease or physical defect or activation of any such latent condition resulting from such injury, medical and related expenses for hospitalization, doctors, medical and nursing care and treatment obtained in the past or to be obtained in the future, loss earnings in the past and any loss of ability to earn money sustained in the past or any such loss in the future, any and all claims for permanent disability or injuries, derivative damages to include any loss of support, services, comfort, society, and attentions in the past and in the future.

I have read the foregoing of this release and hold harmless agreement and fully understand it.

Client's Signature: _____ Date: _____

Parent signature if Minor: _____

Staff's Signature: _____ Date: _____