BUMP & BRUISE CLINIC

Musculoskeletal INSTITUTE OF COMMUNITY MEMORIAL HOSPITAL

Patient Information

Date: _____

Patient Name: _____
(LAST) (FIRST) (MIDDLE)

Date of Birth: _____ Sex (circle one): Male Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Family Physician: _____

E-Mail: _____

Sport: _____ School: _____ Coach: _____

Parent/Guardian Information

Name: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE)

Street Address: (if different from above) _____

City: _____ State: _____ Zip Code: _____

Treatment Authorization/Financial Policy – *NOTE: We MUST have an authorizing signature from a parent or guardian for all athletes under age 18 before an evaluation can occur.*

The above information is true to the best of my knowledge.

I hereby give consent to Community Memorial Hospital and its athletic training staff to evaluate and treat

_____ at the Bump & Bruise Clinic. I understand the initial evaluation and any
STUDENT NAME

minor treatment given at the Bump & Bruise Clinic will be FREE of charge. However, any services including, but not limited to, follow-up physician office visits, x-rays or other diagnostic testing, and therapy are not free and will be billed to my insurance or I will be responsible for payment. I also understand that any follow-up care will be my responsibility.

I understand the Bump & Bruise Clinic is an opportunity to have sports-related injuries evaluated by a certified athletic trainer. Assessments and recommendations for treatment may include follow-up evaluation by a family physician or specialist, x-rays or other diagnostic testing, physical therapy, a home exercise program, alteration in the training program, or a change in equipment. I acknowledge that no guarantees have been made to me regarding treatment.

Signature of Patient (or Parent/Guardian if under 18): _____ *Date:* _____