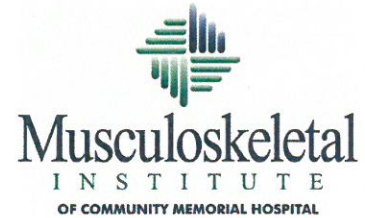


## BUMP & BRUISE CLINIC



### 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: \_\_\_\_\_