# ATHLETE INFORMATION FORM

Date _____

Last Name_____First Name_____

Date of birth_____Sex_____Age____Height____Weight_____

Athlete Social Security Number _____

Sport(s) Participated _____Group _____

Address_____City_____State_____Zip_____

Parent / Guardian:_____Relationship_____

Phone (H)_____(Cell)_____(Other) _____

(Email) _____

Primary Care Physician_____Phone Number _____

**Primary Insurance Information – PLEASE ATTACH A COPY OF INSURANCE CARD**

Insurance Company Name_____Phone Number ____

Claims Address ____

_____ Policy Number_____

_____Group Number_____

Name of Policy Holder_____Employer _____

Policy Holder Date of Birth_____Sex_____Relationship _____

Social Security Number of the primary card holder: _____

**INFORMED CONSENT, WAIVER OF LIABILITY AND RELEASE**

I have been provided a copy of the **Liability Waiver, the HIPPA Notice of Privacy Practices & the HIPPA Release form,** carefully read this waiver of liability, informed consent and release, HIPPA Notice of Privacy & the HIPPA Release form; and fully understand, agree with, and accept its terms and conditions as outlined. I have also received and reviewed a copy and agree with the terms and conditions in this form/release.

**Notice of Patient Privacy**

Health Insurance Portability and Accountability Act (HIPAA)

Performance Evaluation Group, LLC is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

We have available a detailed NOTICE OF PRIVACY PRATICES ("Notice") which fully explains your rights and our obligations under the law.

We may revise our Notice from time to time.

You have the right to receive a copy of our most current Notice in effect

Print Name: _____

Signature: _____ Date: _____/_____/_____

# Performance Evaluation Group, LLC

INFORMED CONSENT, WAIVER OF LIABILITY AND RELEASE

**INFORMED CONSENT**

I, being the parent, legal guardian, or custodian of the minor child involved in the concussion evaluation (herein "my child") and a student or sports participant at the school or organization identified (the "School" or Organization) and, hereby VOLUNTARILY REQUEST and CONSENT, and give authorization to **Performance Evaluation Group, LLC** an Ohio limited liability company ("**PEG**"), to conduct a concussion evaluation to obtain a baseline that may be used in the future as a comparative, when a concussion has been identified ("Evaluation"). This Evaluation includes a cognitive test and a movement baseline assessment of my child's balance reaction time, acceleration, deceleration, speed and heart rate recovery using movement baseline technology. I understand that the information obtained during the course of this evaluation of my child may be shared with a physician who is authorized to treat my child if a concussion has been identified.

I understand and acknowledge that in order to conduct the Evaluation, my child will need to conduct movements in a game like situation in order to most accurately obtain and measure my child's baseline data. I further understand and acknowledge that this testing carries risks similar to those that occur during my child's participation in sporting activities, such as the risk of injury, illness, and any risks associated with an increased heart rate, including but not limited to, cardiac arrest and death.

I represent that my child has had a current physical performed by a duly licensed physician, and that my child has been cleared to participate in vigorous activities and exercise, including sporting activities. In the event that a medical emergency occurs during my child's Evaluation, I hereby consent to any necessary treatment for my child, by PEG or its contractors or any third party. I understand and guarantee all financial responsibility for all medical expenses and costs incurred in the event that my child receives treatment for a medical emergency.

I further voluntarily request and consent for a licensed physician to review and evaluate the results of my child's Evaluation.

**NO GUARANTEE OF RESULTS; WAIVER AND RELEASE OF LIABILITY**

I understand that PEG does not diagnose, treat or identify any concussion. Rather, PEG merely provides a baseline concussion evaluation for the purpose of being used as a comparative reference when a concussion has been identified. Therefore, I acknowledge and agree that PEG can make no, and does not make and expressly disclaims, any warranty or guarantee that a concussion has been identified. I hereby absolutely, fully, and forever release, relieve, waive, and relinquish PEG of any liability of the tests being performed by PEG.

As such, I, on behalf of myself and my child and/or assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives (the "Releasing Parties"), release PEG, the school, organization, and any and all of their respective directors, officers, employees, child, whether due to the inherent limitations in the testing procedures, volunteers, agents, contractors, and representatives (the "released parties") of and from any and all actions or causes of action, actual or alleged claims, of any kind or undiscovered, accrued or un-accrued, suspected or unsuspected, which any Releasing Party may now have claim to have, or which may at any time hereafter accrue, arising out of, in connection with , in consequence of, in any way involving, or related to the performance, interpretation and communication of the results of any of the tests or testing as described in this document, including but not limited to any failure to detect any condition which results in the personal injury to or death or negligence of any of the released parties, or otherwise. I also agree that I, my child, assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue, or attach the property of any release in connection with any of the matters covered by the foregoing release.

I further understand PEG is not responsible or liable for, and each expressly disclaims, the outcome and or performance of any review and or evaluation, and any concussion or recommendation, by any physician, doctor, or other licensed medical of any testing conducted on my child, by PEG, including negligence or medical malpractice on the part of such physician, doctor, or another licensed medical professional.

I recognize and acknowledge that I am personally responsible for taking appropriate follow-up and additional necessary actions on behalf of my child upon receipt of any results from any of the tests, including but not limited to following up with a licensed physician regarding any detected concussion, and ensuring that my child refrains from any physical activities. I understand that follow-up care and treatment for my child is not a part of the testing or services offered by PEG and are solely my responsibility.

**RELEASE OF RESULTS**

I voluntarily request and authorize PEG to disclose and release any and all information obtained about my child or results obtained during this Evaluation to my child's school athletic trainer, my child's team physician, my child's coach, a consulting neurologist or neuropsychologist if applicable, the treating physician(s) in the event of my child's head injury, and/or any other physician(s) designated by me (collectively, the "Authorized Parties"). This authorization shall be effective for all past, present, and future periods.

By signing this document, I also hereby voluntarily agree that PEG, its subsidiaries and affiliates, shall retain ownership of all de-identified information, including demographic information and health history information, and results obtained during the Evaluation of my child ("De-Identified Information"). I further agree that PEG may transfer, exchange, sell, lease, or otherwise assign partial or complete rights, ownership, and title to this De-identified Information to a third party for any lawful purpose, including research. I also give consent to the inclusion of the De-Identified Information in a research data bank which will be used to provide normative data for further research and investigations on concussions.

**PAYMENT FOR TESTING**

I understand and acknowledge that payment must be submitted at the time of my child's Evaluation. In the event that I provide insurance for testing of my child, I understand and acknowledge that all services will be billed by the healthcare providers and facilities actually providing services, and that these services are conducted by PEG as a contracted service with third party hospitals and physicians. I understand it is my responsibility to determine whether the contracted hospitals and physicians are covered by my child's insurance plan. I guarantee payment, including co-insurance and/or co-payments if applicable, for my child's Evaluation and any other services performed.

**REVIEW OF CONTENT**

I have read the forgoing carefully and I fully understand its content. I have had reasonable opportunity and a period of time to consult with an attorney regarding the form and substance of this document if I desired or thought it advisable. Any questions that I might have concerning this information and consent have been answered to my satisfaction. I understand that I may be present if I wish during the course of any and all of the testing being performed on my child as described above.

**Signature of Parent/Guardian/Legal Custodian:** Acknowledged and agreed, I hereby voluntarily consent to the testing of the minor child involved in the concussion evaluation by PEG to document baseline information that will be used as a comparative if a concussion has been identified, and further agree to the waiver of liability, and agree to the release of the results of the testing, all on the termed and conditions stated, and as described in further detail, above.

**I therefore confirm the release of liability of Performance Evaluation Group, LLC and those other persons listed above in this Informed Consent, Waiver of Liability and Release form in connection with the baseline testing as described in this form. I understand that payment must be submitted in order for testing to be conducted, I understand that my child must be present 30 minutes prior to the scheduled test and NO refunds will be made for missed appointments.**

**Notice of Privacy Practices**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.**

We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our notice, we will post the revised notice in the facility and will have them available upon request. You can receive a copy of the current notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclosure your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter state or federal law regulating the privacy of your PHI, we will comply with the more strict provisions of law.

We may post this Notice or revisions on our website.

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

**Treatment**. We may use your PHI to treat you. For example, you may be asked to have a CT scan to assess the brain after injury. We may use the results to help us reach a diagnosis. We may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

**Payment**. We may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

**Health care operations**. We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations as permitted by law.

**Business Associates.** It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

**Treatment Alternatives**. We may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

**Individuals Involved in Your Care or Payment of Your Care**. We may, subject to specific limitations, disclose your PHI to friends or family involved in or who help pay for your health care. We also may disclose your PHI as necessary in case of a medical emergency.

**As Required by Law**. We will disclose your PHI when required to do so by federal, state or local law.

**Contacting You**. We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. For example, we may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

**THE FOLLOWING USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR AUTHORIZATION**: (i) uses and disclosures for marketing purposes; (ii) uses and disclosures that constitute the sale of protected health information; (iii) uses and disclosures of psychotherapy notes; and (iv) other uses and disclosures not described in this notice.

## SPECIAL USE AND DISCLOSURE SITUATIONS

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting organizations such as The Joint Commission, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, worker's compensation purposes, and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response too valid judicial or administrative orders.

We may use or disclose your medical information for research purposes where appropriate.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

***Restrictions on Use and Disclosure of Individual Health Information***. You have the right to request that we restrict how we use and disclose your health information. You may ask us not to disclose a part of your PHI if you have paid for the services related to that treatment when we might otherwise have billed someone else for those services. You may also request that a part of your PHI not be disclosed to family members or others involved in your care. These restrictions must be made in writing to our Privacy Officer and signed by you or your representative. Any request must specify the specific restriction requested and the persons that the restriction applies to. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.

***Access to Individual Health Information.*** You have the right to inspect and copy your health information. All such requests must be made in writing to our Privacy Officer and signed by you or your representative. Under some circumstances, you may not be able to review your PHI such as psychotherapy notes, records related to legal proceedings, or as otherwise restricted by law. We must make PHI available in electronic format upon request and where available. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

***Amendments to Individual Health Information.*** You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny

your request for amendment and you will be given written notice that will explain the basis and your right to appeal. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Officer.

***Accounting for Disclosures of Individual Health Information.*** You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. The right to receive this information is subject to certain exceptions, restrictions, and limitations. Some fees may apply.

***Notification of Breach***. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your PHI.

***Right to a Paper Copy of this Notice***. You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to the Privacy Officer.

***Right to File a Complaint***. If you believe that we may have violated your privacy rights, or you disagree with a decision we about access to your PHI, you may file a complaint with the Privacy Officer listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

***Right to provide an authorization for other uses and disclosures***. We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

**Contact: Privacy Officer**

If you have questions about this Notice or any complaints about our privacy practices, please contact our privacy officer at P.O. Box 524 Wadsworth, OH 44282 or (330) 595-2025 (local) or (855) 487-2937.

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION ("AUTHORIZATION")**

| **Patient Information** | | |
|---|---|---|
| Name (First, Middle, Last) | | |
| Street | City | State |
| Date of Birth | Phone Number | |

| **Release of Information (Check all that apply)** | **Release Information To:** | | |
|---|---|---|---|
| □ Patient History and Physical | Name of Recipient | | |
| □ Baseline Assessment Results and Reports | Street | | |
| □ Other _____ | City | State | |
| | Phone Number | Fax Number | Email |

I, the undersigned, authorize Performance Evaluation Group, LLC to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes.

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice sent to P.O. Box 524 Wadsworth, OH 44282. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider. If Authorization is not complete, signed and dated, it may be