LONGVIEW ORTHOPAEDIC
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Pre-Saturday Clinic Check-List for Parents

Parent/Guardian,

Please review this list of items so we may assist your family with timely care for your injured child. The physician evaluation and on-site x-rays (if deemed necessary by the physician) offered by the Longview Orthopedic Clinic Association's (LOCA) Saturday Morning Sports Injury Clinic are provided at no charge. However, there may be follow-up services recommended with associated costs that will require payment and/or health insurance utilization. Having the necessary paperwork and information with you will help to expedite any services recommended by the physician.

- ✓ Please print and complete the **SPORTS CLINIC REGISTRATION** form on this web-site and bring with you. If you do not have a printer, we will have registration paperwork for you upon arrival.

- ✓ Please bring your **DRIVER'S LICENSE** and **HEALTH INSURANCE CARD** or related document that shows medical coverage for your child.

    - *In the event that your child would require services that are recommended and not part of the free services offered by the LOCA Saturday Morning Sports Injury Clinic, your health insurance, Healthcare Spending Account (HSA) and/or personal funds may be required for payment. Those services not provided by the LOCA Saturday Morning Sports Injury Clinic may include but are not limited to: MRI, CT Scan, Surgical Procedures, Bracing or other follow-up Clinical Office Visits, etc.*
    - *Not all health insurance plans will allow for services to be rendered on Saturdays and may require you to visit your Primary Care Physician before further services can be provided. Once identified, our staff will discuss those circumstances with you in order to help you navigate the challenges of some health insurances.*

- ✓ Please bring a <u>*completed and signed*</u> **STUDENT ACCIDENT CLAIM FORM**. This document is sometimes referred to as the "*School Insurance*" form. There is a portion for your school administrator to complete and a portion for you to complete. Your school's athletic director, coach or athletic trainer will provide this to you upon request if your child's school provides such a policy.

    - *Most (but not all) school districts provide a supplemental student accident policy that helps to off-set some of the expenses that families may incur when their child becomes injured.*
    - *These supplemental student accident policies are considered secondary to your primary health insurance for accidents that occur while your child is participating in a school sponsored athletic contest.*

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2020 SATURDAY SPORTS INJURY CLINIC

Patient Name: ____**Date of Birth**: _______________________

Today's Date: __________ Age: _____ Social Security Number: ____________________ Sex: ❑ Male ❑Female

Address: ____

Parent Name (if minor): ____

Parent Phone (if minor): ____ ❑Home ❑Mobile ❑Work

Alternate Phone: ____ ❑Home ❑Mobile ❑Work

Email (*Parent's email if patient is a minor*): ____

Primary Care Physician: ____

Primary Insurance: _________________________ ID #: ______________________ Group #: ________________

School Insurance: ____ ID #: ________________________

Area of Body Injured ❑ Left ❑ Right: _______________________ Date of Injury: ______________________

How did this injury happen? ____

____

Did this injury occur while participating in a school athletic event? ❑ Yes ❑ No

Sport: ____________ Name of Coach/Athletic Trainer: ___________________ School: ____________________

Have you received care from another healthcare provider for this problem? ❑ Yes ❑ No

If yes, whom & when: ____

<u>Patient Health History:</u>

Allergies: _________________________________ Medications: ____

Do you have any implants? ❑ Yes ❑ No If **Yes**, Please List: ____

Are or could you be pregnant? ❑ Yes ❑ No

How did you hear about Longview Orthopedic Saturday Sports Clinic?
❑School Coach/Athletic Trainer ❑Google ❑Facebook ❑Family/Friends ❑Other: ___________________

Signature: ______________________________ **Date:** _____________________

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STUDENT ATHLETE CONSENT FOR TREATMENT AND CARE

I, ________________________________, parent or guardian of ____________________________ recognize that as a result of athletic participation, medical treatment on an emergency or nonemergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for such medical care. I do hereby authorize in advance to such emergency and non-emergency care, including hospital care, as may be deemed necessary under the then existing circumstances. The purpose of this release is to authorize the school to obtain, through a physician of its choice, any medical care that may become reasonably necessary for the student in the course of school athletic activities or school travel.

Additionally, I give my permission and consent for the evaluation and treatment of my child by the physicians at the Longview Orthopaedic Clinic Association (LOCA), including LOCA's Saturday Sports Injury Clinic.

I hereby consent to and permit Longview Orthopaedic Clinic Physicians/Staff (and/or their designee) to provide evaluation, medical treatment (including emergent or urgent treatment if necessary) to me/my child and physician follow-up according to their medical judgment at the Longview Orthopaedic Clinic Association (LOCA) and/or its Saturday Morning Sports Injury Clinic.

I further authorize Longview Orthopaedic Clinic Association (LOCA) to obtain and release personal medical/insurance data about me for treatment payment or operations related to my injury, illness, physical examination(s) in accordance with the applicable state and federal privacy laws.

I am of sound mind and competent to sign this form.

I have read this form, understand it and agree to the terms and conditions.

____ _______________________________
Parent/Legal Guardian signature Date

____ _______________________________
Student/Athlete (if 18 years of age or older) Date

STUDENT ATHLETE PRIVACY FORM

Authorization for Disclosure of Protected Health Information

I, _______________________________, parent or guardian of __________________________ (the “student athlete”), hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel represent Longview Orthopaedic Clinic Association (LOCA)’s Sports Medicine to release information regarding the student athlete’s protected health information and related information regarding any injury or illness during the student athlete’s training for and participation in athletics at _________________________ School (the “School”). This protected health information may concern the student athlete’s medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics, Saturday Morning Clinics, and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of _____________ College and the ______________ School District.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete’s protected health information is a condition for the student athlete’s participation in interscholastic sports at the School. I understand that the student athlete’s protected health information is protected under federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the School’s athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

______________________________ ____________________________________

Print Student Athlete Name Signature of Parent/Legal Guardian

____

Date

NOTICE OF PRIVACY PRACTICES

By signing above, I acknowledge that I have received or have been offered a copy of Longview Orthopaedic Clinic Association (LOCA)’s Notice of Privacy Practices.