Authorization of Consent and Release of Information
For
SPORTS PHYSICAL OF A MINOR

I hereby authorize Boston Mountain Rural Health Center to conduct a **sports physical** for _____, a minor, for whom I am legally responsible. I am fully aware that by signing this authorization, I am giving Boston Mountain Rural Health Center permission to render routine care associated with the sports physical.

I grant permission for the school personnel to transport and accompany the above named student to BMRHC for his/her sports physical.

As with all other health-related matters, health information cannot be released without consent. I therefore also hereby authorize Boston Mountain Rural Health Center to release sports physical results to my school, _____.

I understand that the above named student will not be allowed to participate in any school related sports without my signature on this form.

_____ _____

Parent/Legal Guardian Signature

BOSTON MOUNTAIN
Rural Health Center, Inc.
A Baptist Health Affiliate

CONSENT TO TREATMENT

Name of Patient: _____

I hereby voluntarily consent on behalf of (**CHECK ONE**) ☐ myself ☐ a minor for whom I am legally responsible (the "Patient") to outpatient care from Boston Mountain Rural Health Center, Inc. ("Boston Mountain"), including: examination, diagnosis, and medical treatment. I further consent to the performance of medically necessary diagnostic procedures, examinations, and medical treatment by Boston Mountain's medical personnel. I understand that this consent remains in effect so long as the Patient is a patient of Boston Mountain.

Authorization to Release Information
I hereby authorize Boston Mountain to release any necessary information acquired in the course of the Patient's examination or treatment to any authorized agent related to treatment, payment, or healthcare operations.

Acknowledgement
I acknowledge that I am responsible for the payment of the Patient's account balance.

Notification of Privacy
I have received a copy, read, and understand the Boston Mountain Notice of Privacy Practices.

Authorization to Access Medical Records
I hereby authorize Boston Mountain to access the Patient's medical records and protected health information.

☐ (**CHECK IF APPLICABLE**) I authorize the following individual(s) to consent to and authorize medical treatment for the Patient:_____

Full Name	Relationship to Patient	Telephone Number
Full Name	Relationship to Patient	Telephone Number

Authorization to Pay Benefits to Boston Mountain

(**CHECK ONE**)

☐ Private Insurance

I authorize Boston Mountain to file insurance and third party payor claims for services rendered to the Patient. I understand that insurance is filed as a courtesy and that I am responsible for payment of all services within ninety (90) days. I also authorize the release of all necessary medical information as needed for reimbursement from my insurers. I authorize payment of medical benefits by any insurance, whether to Boston Mountain or myself.

☐ Medicare Insurance

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information related to services provided to the Patient and reimbursed by Medicare. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify Boston Mountain of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits may apply.

☐ Medi-Gap

I authorize any holder of medical or other information about me to release to Boston Mountain any information related to services provided to the Patient that is subject to "Medi-Gap" coverage. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand that Boston Mountain may not accept assignments on all Medi-Gap claims. I agree to be responsible all amounts not covered by Medi-Gap coverage.

I understand and agree to this form on behalf of the Patient.

_____	_____	_____	_____
Name	Relationship to Patient (if not you)	Signature	Date

BOSTON MOUNTAIN
Rural Health Center, Inc.
A Baptist Health Affiliate

First Name: _____ MI: _____ Last Name: _____

Address: _____

City *State* *Zip Code*

Sex(Circle): **Male, Female, Transgender, Unknown**

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ Social Security #: _____ Email: _____

Employer: _____ Work Phone: _____Cell Phone_____

Ethnicity(circle): **Hispanic or Latino, Not Hispanic, Refused to Report**

Race(circle): **Asian, American Indian/Alaska Native, Black/African American, Native Hawaiian, Pacific Islander, White, More Than One Race, Unreported/Refused to Report Race**

Primary Language(circle): **English, Indian, Spanish, Russian, Other**

Marital Status(circle): **Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown**

Veteran (circle): **Yes/No**

Agricultural Worker: Yes/No *(If "Yes," please specify: seasonal, migrant, employed farm worker, unemployed farm worker)*

Start Date: _____ Stop Date: _____

Public Housing: Yes/No Start Date: _____ Stop Date: _____

Homeless: Yes/No Start Date: _____ Stop Date: _____

(If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)

Primary Insurance Information

Name: _____ DOB: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Relationship to Patient: _____

ID#: _____ GROUP#: _____

Secondary Insurance Information

Name: _____ DOB: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Relationship to Patient: _____

ID#: _____ GROUP#: _____

Minor Information (If Applicable)

Father's Name: _____DOB: _____ SS#: _____

Home Phone: _____Cell Phone: _____

Mother's Name: _____ DOB: _____ SS#: _____

Home Phone: _____Cell Phone: _____

Legal Guardian (If Applicable) _____ **VERIFICATION REQUIRED**

Pharmacy Name: _____ **Location**:_____

I hereby certify that the above information is correct.

_____ _____

Patient or Responsible Party Signature Date

Boston Mountain RURAL HEALTH CENTER, INC.

Sports Physical Form

First Name: _____ Last Name: _____

DOB: _____ Sex: _____ Social Security Number:_____

Briefly explain any "Yes" answers at the bottom of this page

Has anyone in the athlete's family (grandmother, grandfather, mother, father, sister, brother) died suddenly before the age of 50?	Yes	No
Has the athlete ever passed out during exercise or after exercise, or stopped exercising because of extreme dizziness?	Yes	No
Does that athlete have asthma?	Yes	No
Has the athlete ever sprained, strained, dislocated, fractured, broken, had repeated swelling or any other injury to any bones, joints or muscles?	Yes	No
Has the athlete ever suffered a concussion, been knocked out, or had any other head injury?	Yes	No
Has the athlete ever suffered a heat-exhaustion, heatstroke, been dizzy or passed out because of the heat?	Yes	No
Does the athlete have anything he or she wants to discuss with the physician?	Yes	No
Does the athlete have any chronic illnesses or see a physician regularly for any particular problem?	Yes	No
Does the athlete take any prescribed medicine?	Yes	No
Does the athlete have any allergies? (medication, bee stings, etc.)	Yes	No
Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?	Yes	No
Has the athlete ever been hospitalized?	Yes	No
Has the athlete ever had chest pain during or after exercise?	Yes	No
Does the athlete tire more quickly than others during activity?	Yes	No
Has the athlete ever had high blood pressure?	Yes	No
Has the athlete ever been told they have a heart murmur?	Yes	No
Has the athlete ever had racing of the heart or skipped beats?	Yes	No
Has the athlete ever had a seizure?	Yes	No
Has the athlete ever had a stinger, burner or pinched nerve?	Yes	No
Has the athlete ever had heat or muscle cramps?	Yes	No
Does the athlete cough or have trouble breathing during or after activity?	Yes	No
Does the athlete use any special equipment? (pads, braces, mouth guard, etc.)	Yes	No
Has the athlete had any problems with their eyes or vision?	Yes	No
Does the athlete wear glasses, contacts or protective eye wear?	Yes	No
Does the athlete have any other medical problems?	Yes	No
Has the athlete had any medical problems or injuries since their last evaluation?	Yes	No

If yes, please explain:

_____

Boston Mountain RURAL HEALTH CENTER, INC.

Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: R: 20/____ L: 20/____ Both Eyes: 20/____ Corrected: Yes____ No____

(Best vision with both eyes must be 20/50 or better)

	Normal	Abnormal
Eyes/Nose		
Mouth		
Neck		
Heart		
Lungs		
Abdomen		
Skin		
Edema		

Joints	Normal	Abnormal
Shoulders		
Elbows		
Wrists		
Hips		
Knees		
Ankles		
Scoliosis		

Explain: _____

_____Pass
_____Pass With Recommendations: _____
_____Pass With Restrictions: _____
_____Unable To Participate Without Further Evaluation By A Doctor

_____ _____
BMRHC Medical Provider Signature Date

BY SIGNING THIS FORM, THE PARENT OR LEGAL GUARDIAN IS GIVING PERMISSION FOR A SPORTS PHYSICAL TO BE PERFORMED ON THE CHILD AND AGREEING ALL INFO IS CORRECT. PHYSICAL WILL NOT BE COMPLETED IF THE FORM IS NOT COMPLETED AND SIGNED BY PARENT OR LEGAL GUARDIAN.

_____ _____
Parent/Legal Guardian Signature Date