Concussion Testing

SCAR Sports Conditioning and Rehabilitation
Get Healthy. Stay Healthy. Play Healthy.

Sports Medicine

BASELINE CONCUSSION TESTING
PATIENT INFORMATION PACKET

Personal Information:

Last Name:	First Name:	Birth Date:	M / F
Home Phone:	Cell Phone:		
E-Mail:	Permanent Street Address:		
City:	State:	Zip:	

Athletic Information:

School/Club:	Sport(s):	Position(s):
Coach Name:	Phone:	E-Mail:

Concussion History:

Have you ever experienced a concussion before? *Yes No* How many concussions have you sustained? 1 2 3 4+

Date(s) of previous concussion(s):

Did you experience any of the following signs or symptoms:

Loss of consciousness	*N*	*Y*	Balance problems	*N*	*Y*	Sensitivity to light	*N*	*Y*
Numbness or Tingling	*N*	*Y*	Dizziness	*N*	*Y*	Sensitivity to noise	*N*	*Y*
Neck pain	*N*	*Y*	Fatigue	*N*	*Y*	Irritability	*N*	*Y*
Headache	*N*	*Y*	Trouble falling asleep	*N*	*Y*	Sadness	*N*	*Y*
Nausea	*N*	*Y*	Sleeping more than usual	*N*	*Y*	Feeling more emotional	*N*	*Y*
Vomiting	*N*	*Y*	Drowsiness	*N*	*Y*	Nervousness	*N*	*Y*
Difficulty concentrating	*N*	*Y*	Feeling mentally foggy	*N*	*Y*	Anger	*N*	*Y*
Difficulty remembering	*N*	*Y*	Visual problems	*N*	*Y*	Neck Injury	*N*	*Y*

Do you have a learning disability or disorder: Yes No If yes, please list:

Are you currently on any Medications: Yes No *Please List (include non-prescriptions):*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

Athlete Signature: *Date:*

Parent or Guardian Signature: *Date:*

Athletic Trainer Review:

Athletic Trainer Signature: *Date:*

Concussion Testing

SCAR Sports Conditioning and Rehabilitation
Get Healthy. Stay Healthy. Play Healthy.

Sports Medicine

CONSENT FOR CONCUSSION TESTING

I, _____ (Print Patient Name or Guardian), give consent for baseline and/or post concussion testing through Sports Conditioning and Rehabilitation. I understand that Baseline Concussion Testing is designed to give objective measurements in determining return to physical activity and sport in a safe and efficient manner after sustaining a concussion. I understand ImPACT and BioSway are not designed to diagnose a concussion and are used as a tool to guide the return to play process. Sports Conditioning and Rehabilitation is not responsible for clearing athletes for return to physical activity. Athletes should be under the care of a physician and all concussion tests should be assessed and interpreted by a physician.

_____ _____

Signature (Parent or Guardian if under 18) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and disclosure of protected health information is regulated by the federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I _____ (Print Patient Name or Guardian) acknowledge that Sports Conditioning and Rehabilitation of CA, Inc, has provided a written copy of its Notice of Privacy Practices for Protected Health Information to myself/guardian.

_____ _____

Signature (Parent or Guardian if under 18) Date

CONFIDENTIALITY

In the event that we need to contact you:

Which phone number would you prefer we call (please circle all that are acceptable)? *Cell* *Home* *Work*

May we leave a message on an answering machine or with someone at the acceptable numbers? *Yes* *No*

May we contact you by e-mail? *Yes* *No*

Is there anyone besides your physician you give us permission to talk to regarding your fitness, sports medicine or physical therapy care? *Yes* *No*

If yes, please list:_____

_____

_____ _____

Signature (Parent or Guardian if under 18) Date

RELEASE OF LIABILITY

I,_____, do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation or use of computerized equipment or machinery designed for purpose of baseline and post-concussion testing.

_____ _____

Signature (Parent or Guardian if under 18) Date

_____

Print

SUMMARY OF NOTICE OF PRIVACY PRACTICES

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") goes into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice.

YOUR RIGHTS AS A PATIENT. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

USE OF PROTECTED HEALTH INFORMATION. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible. For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR AUTHORIZATION. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

DISCLOSURES OF PROTECTED HEALTH INFORMATION NOT REQUIRING YOUR AUTHORIZATION. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

COMMUNICATION TO YOU OF CONFIDENTIAL INFORMATION BY ALTERNATIVE MEANS. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

RESTRICTIONS TO USE AND DISCLOSURE. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

ACCESS TO PROTECTED HEALTH INFORMATION. You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

AMENDMENTS TO MEDICAL RECORDS. You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

OTHER USES OF YOUR HEALTH INFORMATION. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights. *You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation. For a full copy please call Sports Conditioning and Rehabilitation 714-633-7227.*