



**ASSIGNMENT AND RELEASE**

By signing this form, I consent to and authorize CHAS Health to treat me. If this patient is a minor or unable to sign for themselves, I, as a legal guardian or power of attorney, consent to treatment of this patient.

**I understand and agree that:**

1. I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance.
2. I am financially responsible for all fees generated for services, supplies, and equipment provided by an outside provider (e.g. lab work) and that the outside provider may bill me directly for those fees.
3. Benefits of my insurance are assigned to CHAS Health.
4. These terms are non-negotiable. Attempts to modify these terms are void and my acceptance of healthcare services constitutes my full agreement with these terms.
5. I may receive healthcare through telephone or video connection, referred to as Telehealth. While telehealth has several benefits including increased access to healthcare, there are risks. I have the right to refuse treatment through telehealth at any time. Risks related to malfunctioning equipment or poor phone or internet connection may disrupt or delay care. In-person visits may be required. In very rare instances, security protocols could fail causing a breach of privacy or personal medical information. Please refer to the CHAS Notice of Privacy Practices for more information about how we secure private data
6. **I authorize CHAS Health to communicate with me using unsecure SMS text messaging, regarding my health care that may include protected health information.** I understand that exchanging email, text, or other written communications with my care team can result in disclosure of protected health information to unauthorized persons and that CHAS cannot control who views such information when sent unsecured. If I initiate or respond to communications using unencrypted pathways, I assume the risk that my information may be seen by a third party.

**I understand that I may opt-out of texting by replying 411stop at any time.**

I understand that I am not required to consent to receive text messages to receive services and that I may elect to sign a different form that excludes this text message consent.

I understand that I am responsible for any costs associated with me receiving text messages, including data fees from my wireless carrier.

7. I authorize CHAS Health to contact me by telephone to remind me of appointments or to discuss my protected health information.
8. If I fail to keep my appointments or provide late notice of cancellation (within 4 hours of schedule appointments) three times in a three-month period, I may be restricted to same day only scheduling or walk-in status.

**Electronic signatures.** By signing below I agree that this document is deemed signed when a party's signature is delivered electronically. The signor is executing this document electronically and intends to be bound by the terms, statements and consents contained in this document and agrees that the electronic signature shall be deemed original signatures having the same legal effect as original signatures to the fullest extent permitted by applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, and any similar state law based on the Uniform Electronic Transactions Act, and the parties hereby waive any objection to the contrary. The signor acknowledges that this term is hereby incorporated into the Agreement/Document.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date



## About Our Notice of Privacy Practices

The CHAS Health is committed to protecting your personal health information. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information
- how we may use and disclose the health information that we keep about you
- your rights relating to your personal health information
- how to file a complaint if you believe your privacy rights have been violated
- the conditions that apply to uses and disclosures not described in this Notice
- the person to contact for further information about our privacy practices

We are required by law to give you a copy of this notice and to obtain your written acknowledgment that you have received a copy of this notice.

**BY MY SIGNATURE BELOW,  
I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.**

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Signature of Patient or Authorized Representative

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Date

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Printed Name if Signed on Behalf of Patient

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Relationship (parent, legal guardian, personal rep, etc)

This form will be retained in your Medical Record.

**CHAS Health Patient Acknowledgment of Receipt of Notice or Privacy Practices**

This form should be placed into the athlete's medical file and should not be shared with schools or sports organizations.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of >3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_