

Parental Release

I hereby give consent to Defiance Clinic to evaluate and treat _____

Athlete's Name

at the Bump Clinic. I understand the initial evaluation and any minor treatment given at the Bump Clinic will be free of charge. However, any services such as x-rays, pharmacy, special tests or braces are not free and will be billed to my insurance or I will be responsible for payment. I also understand that any follow-up care will be my responsibility.

I also understand that there will be a certified athletic trainer, working under the order of a licensed physician, providing the evaluation and treatment. The evaluation and assessment is not meant to be a medical diagnosis. Any tests, medications, or physical therapy that may be needed will be prescribed by the physician on duty at the Clinic.

Parent/Legal Guardian Signature

Patient Signature

Date

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for service provided or benefits for related services.

ASSIGNMENT OF BENEFITS: I authorize payment of benefits be made directly to **DEFIANCE CLINIC** for services provided to me by **DEFIANCE CLINIC**. I understand that I am financially responsible to **DEFIANCE CLINIC** for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature of patient

If minor, then signature of responsible person