OZARKS HEALTHCARE

590598054

Clinic Consent

Patient Name_____

Date of Birth _____/_____/_____ Social Security # _____ Medical Record #_____

The person signing this document certifies that he/she has read the following and is the patient or is duly authorized by the patient as the patient's general agent, legal guardian to execute and accept these terms.

This consent is valid for all Ozarks Healthcare Clinics unless otherwise specified below (excludes Outpatient Departments):

☐ **Excluded Clinics** _____

General Consent: I hereby authorize Ozarks Healthcare to provide health care services as ordered by my physician. I consent to the rendering of such care, which may include routine laboratory, diagnostic and medical treatment, psychological evaluation and/or treatment, counseling and/or coordination of care with other providers and procedures as my physician or other of the clinic/physician office medical staff consider to be necessary. I understand that the practice of medicine and surgery is not an exact science and may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of the examination or treatment in this clinic/physician office. I recognize that some doctors furnishing services in or for the clinic may be independent contractors and are not employees or agents of Ozarks Healthcare or any of its affiliated facilities. Practitioners who are independent will bill separately for the services that they may provide.

Financial Agreement: In consideration for the services to be rendered, I hereby guarantee payment for the services rendered. It is understood that the undersigned as patient/guarantor is responsible for any health insurance deductible and co-insurance payments. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Any and all suits for any and every breach of this contract shall be instituted and maintained in the County of Howell, State of Missouri.

Communications Regarding Account: I agree that Ozarks Healthcare, or any other collection or servicing agency or agencies retained by Ozarks Healthcare (together referred to hereafter as "collectors") to collect any money that may be owed as a result of services rendered pursuant to this document, may contact me by telephone or text message at any number given by me or otherwise associated with this account, including but not limited to cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages or voice mail message. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with this account.

Assignment of Benefits and Payment Request: I hereby authorize payment directly to Ozarks Healthcare or hospital-based physician, any medical benefits otherwise payable to me under Title XVIII and/or Title XIX of the Social Security Act and/or from any health insurance plan. I certify that the information given by me in applying for payment is correct.

Authorization for Disclosure: I give permission to discuss with the individual(s) I have listed:
(Please check appropriate)
_____ Any aspect of my health care _____ Health information Only _____ Financial information Only
I understand that I am responsible for notifying this office, in writing of any changes to this authorization to disclose personal health.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Acknowledgement of Receipt of Notice of Privacy Practices: Our notice of Privacy Practices describes how your medical information may be used and disclosed and how you can gain access to your information. My signature below acknowledges receipt of the Notice of Privacy Practices

Ozarks Healthcare Foundation: I authorize Ozarks Healthcare to release my name, address and phone number to the Ozarks Healthcare Foundation for the purpose of charitable activities of that organization,_____ Yes _____ No I will receive a copy of Ozarks Healthcare's Patient's Rights and Responsibilities Brochure.

_____ Date_____ Time_____

Patient or guardian Signature

MSHSAA Preparticipation Physical Forms/Procedure

Medical History Form (Step 1): Issued to Student/Parent(s)/Guardian, Completed by Student/Parent(s)/Guardian, Taken to Healthcare Professional (MD/DO/ARNP/PA/DC), Retained by Healthcare Professional.

Note: If the student is under 18 years old, the Medical History questions are to be completed with assistance from parent(s)/guardian(s).

Note: The health care professional (MD/DO/ARNP/PA/DC) who completes the pre-participation examination (PPE) shall keep this Medical History form in the patient's files for their records.

This Medical History form is NOT returned to the school.

MEDICAL HISTORY	
Name:	Date of Birth:
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 of your allergies (i.e., 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.

(Medical History Continued – Next Page)

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

GENERAL QUESTIONS	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 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 ordered a test for your heart? (For example, electrocardiography (ECG) or echocardiography?		
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 (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 *Staphylococcus aureus* (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?		
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?		

IF "YES," EXPLAIN ANSWERS HERE

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

Signature of Student:
Signature of Parent(s) or Guardian:
Date:

Preparticipation Physical Examination Form (PPE) (Step 2): Issued to Student/Parent(s)/Guardian, Taken to Healthcare Professional (MD/DO/ARNP/PA/DC), Retained by Healthcare Professional.

Note: This PPE form is the recommended PPE form intended for guiding the healthcare professional (MD/DO/ARNP/PA/DC) with the completion of a preparticipation physical evaluation.

Note: The health care professional (MD/DO/ARNP/PA/DC) who completes the pre-participation examination shall keep this PPE form in the patient's files for their records. **This PPE form is NOT returned to the school.**

PRE-PARTICIPATION PHYSICAL EXAMINATION

Name:		Date of Birth:
EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP) and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal • Hearing		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, auscultation supine and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA) or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test and box drop or step drop test		

* Consider electrocardiography (ECG), echocardiogram, referral to cardiology for abnormal cardiac history or examination findings, or a combination of those.

Physician Reminders:

Consider additional questions on more-sensitive issues.

- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff or dip?
- During the past 30 days, did you use chewing tobacco, snuff or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt, use a helmet and use condoms?

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Proceed to next page for
Medical Eligibility Form

MSHSAA Medical Eligibility Form (Step 3):

Issued to Student/Parent(s)/Guardian, Taken to/Completed by Healthcare Professional (MD/DO/ARNP/PA/DC), Copy Retained by Healthcare Professional, Returned to School Administration.

Note: This Medical Eligibility form is the form to be used by a healthcare professional (MD/DO/ARNP/PA/DC) for granting a medical release for a student to participate in All Sports – Spirit – Marching Band after the completion of a preparticipation physical evaluation.

Note: The health care professional (MD/DO/ARNP/PA/DC) must complete this form, retain a copy in the patient's files for their records and issue this form to the student/parent.

This Medical Eligibility form MUST be returned to the school.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex assigned at birth (F,M, intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

☐ **Medically eligible for all Sports-Spirit-Marching Band without restrictions for two (2) years.**

☐ **Medically eligible for all Sports-Spirit-Marching Band without restriction for two (2) years with recommendations for further evaluation or treatment of:** _____

_____

☐ **Medically eligible for all Sports-Spirit-Marching Band without restriction for less than two (2) years. Specify reasons and duration of approval:** _____

_____

☐ **Medically eligible for certain Sports-Spirit-Marching Band:** _____

☐ **NOT medically eligible for Sports-Spirit-Marching Band**

☐ **NOT medically eligible pending further evaluation:** _____

I have examined the above-named student and completed the pre-participation physical evaluation. Unless otherwise indicated, the student does not present apparent clinical contraindications to practice and participate in the sport(s) or activities as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Name of health care professional (Print/Type) _____ Date of Examination ___/___/___

Signature of Healthcare Professional (MD/DO/PA/ARNP/DC): _____

Clinic Address _____ City _____ State _____ Zip _____

Telephone _____

Student's Physician _____

Student's Dentist _____

MSHSAA PRE-PARTICIPATION DOCUMENTATION – ANNUAL REQUIREMENTS (All Sports & Activities)

CURRENT HEALTH AND INJURY UPDATE (INTERIM MEDICAL UPDATE)	
Note: Complete and sign this form (with your parents if younger than 18). **Note: An injury or medical condition results in a separate medical release.**	
Student Name:	Date of Birth:
Date:	
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 of your allergies (i.e., medicines, pollens, food, stinging insects):	
Have you had any medical conditions/concussions/orthopedic injuries this past year that has resulted in a health care professional (MD/DO/ARNP/PA) denying or restricting your participation in any sport – spirit – marching band?	
If yes to the preceding question, have you provided appropriate documentation to the school clearing you back to such participation by a health care professional (MD/DO/ARNP/PA) for those medical conditions/concussions/orthopedic injuries?	
Are there any medical conditions you wish to disclose to the school that may need attention during the student's participation in any sport – spirit – marching band?	
I hereby state that, to the best of my knowledge, my answers to the questions herein are complete and correct.	
Signature of Student:	
Signature of Parent(s) or Guardian:	
Date:	

EMERGENCY CONTACT INFORMATION		
Parent(s) or Guardian	**Address**	**Phone Number**
Name of Contact	**Relationship to Student**	**Phone Number**

PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)

Informed Consent: By its nature, participation in interscholastic athletics/activities includes risk of serious bodily injury and transmission of infectious disease such as HIV, Hepatitis B, severe acute respiratory syndrome (COVID-19) and/or any mutation or variation thereof. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic/activity programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA- SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student being a minor, but that, if necessary, the student will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics/activities. We also give our consent for him/her to accompany the school group on trips and will not hold the school responsible in case of accident, injury or illness whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

In the event of an emergency or when the Parent(s) or Guardian is unable to directly supervise health care services needed by the student for injuries or illnesses sustained at any athletic/sport and/or activity practice, conditioning exercise or contest, I also give my consent to the rendering of necessary health care services for the student by a qualified provider (QP) covering the athletic/activity practice, conditioning exercise or contest, including an athletic trainer, physician, physician assistant, nurse practitioner or other medically-trained professional licensed by the State of Missouri (or the state in which the student injury or illness occurs) and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by state law. In emergency situations, the QP may also be a certified paramedic or emergency medical technician for the purpose of providing emergency health care and transport. Health care services are defined as services including, but not limited to, evaluation, diagnosis, first aid, emergency care, stabilization, treatment and referral. I further authorize the QP who provides such health care services to disclose such information about the student's injury or illness, diagnosis, care and treatment in the professional judgment of the QP to the student's athletic director, coaches/directors, school nurse and any classroom teacher required to provide academic accommodation to assure the student's recovery and safe return to activity. If the Parent(s) or Guardian believes that the student is in need of further evaluation, treatment, rehabilitation or health care services for the injury or illness, the student may be treated by the physician or provider of his or her choice.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics/activities in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with sixth or seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics/activities is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team or group either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic/activity-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has healthcare insurance coverage or healthcare expense payment plan.

The parent(s) or guardian below verify that the student is covered by a healthcare insurance coverage or healthcare expense payment plan.	☐ **Yes**	☐ **No**

I have read and acknowledge the information presented above and hereby grant consent for the named student to participate.

Signature of Parent(s) or Guardian:	**Date:**

STUDENT AGREEMENT (Regarding Conditions for Participation)

This application to represent my school in interscholastic athletics/activities is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at www.mshsaa.org).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics/activities programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team or group either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics/activities is a privilege and not a right. As a student participant, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Signature of Student:	**Date:**

PARENT AND STUDENT SIGNATURE (Concussion Materials)

I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

Signature of Student:	**Date:**
Signature of Parent(s) or Guardian:	**Date:**

PARENT AND STUDENT SIGNATURE (Injury Risk/Disclosure)

I accept responsibility for reporting all injuries and illnesses, to my school and medical staff (athletic trainer/team physician). We acknowledge that there is a risk of injury by participation in all sports and activities and failure to disclose injuries may result in further complications.

Signature of Student:	**Date:**
Signature of Parent(s) or Guardian:	**Date:**