Welcome to wellbody KC – Focused on the Healthcare of Athletes.

Please complete the documents attached and bring them to your appointment.

Consultations must be paid in full at the time of service (all payments can be made on the web site). You will receive a "Bill for Services" with information on how to request reimbursement for an "out of network visit" from your insurance carrier. There is no guarantee that reimbursement will be obtained.

Thank you – wellbody KC looks forward to getting you well soon!

Thank you.

wellbodyKC

CONSENT FOR EXAMINATION, MEDICAL TREATMENT

Patient/Athlete Name: _____ Date of Birth _____

I authorize wellbodyKC health care providers to consult, examine, and recommend a treatment plan for the patient/athlete above. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this practice. I understand that communication with anyone other than the patient and patient's guardian (if the patient is under 18 years old) is protected by HIPAA.

If marked below, I hereby authorize the following people to bring my child to appointments without a parent or guardian present. I authorize them to consent to any and all examinations, tests, procedures and treatments deemed necessary by the provider. Removing a person from this list to bring my child to an appointment can be done by written request.

If marked below, I hereby authorize wellbodyKC to discuss the diagnosis and/or treatment recommendations with the following people. This may be by written, email, or phone communication and is permitted indefinitely. I realize that this permits a HIPAA release for medical information to be shared with this person and communication may not be secure. Removing a person from this list to receive medical information can be done by written request.

Bring to clinic	Communicate HIPAA release	**Full Name**	**Relationship to Patient**	**Phone # or email**
☐	☐			
☐	☐			

Coach Contact: _____ Email or Phone: _____

☐ I authorize medical diagnosis and treatment recommendations to be discussed with the above named person. Communication may be written, by phone, or by email. I realize that this permits a HIPAA release for medical information to be shared with this person and communication may not be secure. I can remove this person from getting information by written request at any time.

Signature of Parent/Guardian: _____ **Date:**_____
(or Patient/athlete if over 18 years old)
Printed name of Parent/Guardian: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Preferred Communication: please complete both phone and email and mark the one you prefer for communication

☐ **Parent/Guardian Phone:** _____ ☐ **Email:** _____

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Name of Patient/Athlete: _____ Date of Birth: _____

Sport: _____ Level: _____ Team/Club:_____

Practice schedule: Hours per week: _____ or Days per week: _____

Competition Season: (Circle when you are "in season")

Year Round Winter Summer Spring Fall I don't compete
Next scheduled event: _____ I plan to compete/perform at this event: YES NO

1. **Past Medical History:** (include fractures, dislocations, asthma, diabetes, hospitalizations, etc.)

2. **Past Surgical History:** (include ear tubes, tonsillectomy, appendectomy, orthopedic procedures)
   Procedure Date

3. **Medicines I take every day:** (include prescription, over the counter, supplements, vitamins, alternative)
   Medicine Dosage (if you know it)

4. **Medicines I take every once in a while:** (include Tylenol, ibuprofen, creams, alternative)
   Medicine Frequency (daily, weekly, monthly, rarely)

5. **Allergies** to medicines/ foods/ environmental: _____ None

6. I received **immunizations** and am up to date: Yes No

7. **During every week I eat something in this food group:** (Circle what you eat/drink)
   Meat/Fish Fruits Vegetables Grains Water Desserts Soda/Pop

8. **I have had this many stress fractures diagnosed:** (extremity/back): Number: ____ None
   Location:_____

9. **I have had this many concussions:** Number: ____ None

10. **School:** circle one Public/Private _____ Home College I don't go to school
    hours/day

11. **I get this kind of treatment at least once a month:** (circle all that apply)
    Massage PT Chiropractor Dry needling Acupuncture Cryotherapy Other: _____

12. **Today's appointment**: My question / my problem / my concern/ my goals for today: