Athletic Physical Exam Waiver and Consent Form

Please check one option:

☐ I am electing to have a complete wellness exam including the completion of the Iowa Athletic Pre-Participation Physical Examination form. I understand that this exam will be filed to my health insurance. If insurance does not cover this service, I understand that I will be responsible for the charges.

☐ I am electing the completion of the Iowa Athletic Pre-Participation Physical Examination form only. I understand that this is a limited exam that will not be filed to my health insurance. A $30 payment is due upon service.

Patient Name (Please print) _____ **Date of Birth** _____

Address _____

City _____ **Zip**_____

Sex: ☐ Male ☐ Female **Social Security #**_____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Parent/Guardian: _____

Family Doctor _____ **Facility** _____

Insurance Information (include if full wellness exam)

Insurance Coverage _____

Insured's Name _____**Date of Birth** _____

Employer_____**Policy #** _____**Group #** _____

Insurance Claim Address _____

Insurance Phone Number _____ **Effective Date** _____

*****Include copy of insurance card with this form (copy on back of form or on separate sheet of paper).**

CONSENT FOR MEDICAL TREATMENT OF A MINOR

In the event that my child/dependent reports to the Orange City Area Health System for medical care, I do hereby consent to clinic care, including diagnostic procedures and medical treatment deemed appropriate by the Orange City Area Health System medical staff.
I also authorize the Orange City Area Health System to release health and insurance information to any physician, hospital, or other medically related facility involved in my child's/dependent's treatment, in addition to such information may be necessary for the completion of my child's/dependent's insurance claims as a result of treatment received at the Orange City Area Health System.

AUTHORIZATION OF BENEFITS

I consent the release of my medical information for payment purposes to health insurers or third party payers. I hereby authorize payment directly to the provider for insurance benefits otherwise payable to me, but not to exceed the balance due of the provider's regular charge for this period of hospitalization. **I understand that I am financially responsible to the provider for charges not covered by this authorization.**

Signature _____**Date**_____

Orange City Area Health System

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