ONLY HIGHLIGHTED PORTIONS ARE REQUIRED ON THIS PAGE

NOVANT HEALTH

Outpatient Information / Consent to Treat

PARTICIPANT INFORMATION	Account #:	Medical Record #:	Date:
Participant full name:		Referring doctor:	Referring doctor phone #:
Address:		Primary doctor:	
City/State/Zip:		Employer/school of participant:	
(H) Phone #: Cell phone:	Work phone:	Email address of responsible party:	
Social Security #:	Date of birth:	Age:	Marital status: / Sex:
Race:	Ethnicity:	Religion:	
Emergency contact:	Relationship:	(H) Phone #: (C)	
Responsible party:	Relationship:	DOB:	SS#:
Responsible party address:		City/State/Zip:	Phone #:

INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured DOB:	Insured Social Security #:	Insured DOB:	Insured Social Security #:

General Consent: I consent to medical care at Novant Health. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Novant Health is not responsible for any loss or damage to my property.

I understand and agree with the above information. This consent is valid for one (1) year.

Patient or Responsible Person Signature: _____ ***Date*** _____ **Time** _____

Financial Responsibility: I agree to pay for all medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. I am aware that the doctors and others providing care may not be employees of Novant Health. They are acting on their own and not at the direction of Novant Health. I understand I will receive a separate bill for their services. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to Novant Health and any other treating providers. I appoint Novant Health, the other treating providers and/or their agents as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for any unpaid bills I have with any Novant Health facility. I give permission to be contacted via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may be made by businesses helping my providers collect money that I owe.

I understand and agree with the above information. This consent is valid for one (1) year.

Patient or Responsible Person Signature: _____ ***Date*** _____ **Time** _____

*** For delivering mothers, all of these responsibilities apply to your newborn baby.**

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

ENTIRE PAGE NEEDS TO BE COMPLETE

RELEASE AND WAIVER OF LIABILITY

I understand that this Release And Waiver of Liability governs all rights and liabilities directly or indirectly arising out of or related to any "Services," as that term is defined below. I have read, understand, and agree to be bound by the Terms and Provisions below.

Definitions

"Services" shall mean any and all manner of goods and services offered by Novant Health, Inc. and any of its affiliates ("Novant Health") or any other Released Party to you. These services, which may take the form of training, treatment, consulting, and other services, expressly including but not limited to: evaluations; rehabilitation; athletic training, therapy, reconditioning; performance planning; performance training (e.g., strength and conditioning training, speed and quickness training, and plyometric training); recovery and regeneration training; sports nutrition consultation; supplement and nutrition provision; injury reduction and treatment; technical and tactical instruction; performance enhancement; and any consultation related to any item included in this list.

"Training" shall mean any act, omission, or other activity required of you or carried out by you in relation to the Services. This term shall not be limited, in any way, with respect to any location, site or facility at which any activities related to the Services takes place.

"**Released Parties**" shall mean Novant Health, Inc. and all of its affiliates, and each of their respective partners, members, managers, shareholders, officers, directors, agents, employees, insurers, heirs, agents, successors, and assigns.

Terms And Provisions

The risk of injury from participation in sporting events and other strenuous physical activity, including Training, is significant, including the potential for permanent paralysis, other serious injury, and/or death. **I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS** of participation in Training, including, without limitation, risk arising from or relating in any way to the condition of the facilities, equipment, fields, and surrounding premises, the actions of persons other than myself, my own actions, and travel to and from the Training (including, but not limited to, travel services provided by any Released Parties or in any vehicle owned, operated, or associated with any Released Parties). **I UNDERSTAND THAT THE RELEASED PARTIES MAKE NO WARRANTIES (WHETHER EXPRESS OR IMPLIED)** and shall in no event be responsible or liable for the defective or dangerous condition of the facilities, equipment, fields, and surrounding premises, except to the extent such condition(s) result(s) solely from the gross negligence or intentional acts of any Released Parties.

I AGREE THAT THE RELEASED PARTIES SHALL NOT BE LIABLE for any losses, claims, demands, injuries, damages, actions, lawsuits, judgments, fines, penalties, liabilities, costs, expenses (including, without limitation attorneys' and accountants' fees and costs and court costs, whether or not in connection with litigation), or causes of action (collectively, "Damages") that arise in whole or in part due to the simple negligence of any of the Released Parties. **FURTHERMORE, I FOREVER RELEASE AND DISCHARGE, AND AGREE TO INDEMNIFY AND HOLD HARMLESS** the Released Parties from and in relation to all Damages that arise from or relate in any way to my participation in the Training, other than Damages that arise solely from the gross negligence or intentional acts of any Released Parties. **I FURTHER WARRANT AND CERTIFY** that I have no health conditions or defects that would prevent me from participating safely in the Training, that I have taken every reasonable act necessary to make this warranty and certification in relation to such participation, and that I am otherwise sufficiently fit and healthy to so participate.

I WARRANT AND UNDERSTAND that it is my sole and personal responsibility to obtain insurance to compensate for any and all Damages which might arise from my participation in the Training, and furthermore agree to look solely to such insurance to cover such Damages, regardless of fault, and waive all rights of subrogation on behalf of any and all Released Parties which may now or ever exist as a result of such insurance.

IN ANY CASE, THE CUMULATIVE LIABILITY OF ALL RELEASED PARTIES RELATING TO ANY SERVICES PROVIDED AND THIS AGREEMENT WILL BE LIMITED TO THE AMOUNT ACTUALLY PAID BY ME (OR ON MY BEHALF) TO ANY OF THE RELEASED PARTIES DURING THE PERIOD THAT IS ONE (1) YEAR PRIOR TO THE DATE OF THE CAUSE OF ACTION BETWEEN THE LITIGANTS, MINUS ANY AMOUNTS PREVIOUSLY PAID BY ANY OF THE RELEASED PARTIES FOR ANY PRIOR LIABILITY. THE RELEASED PARTIES' LIMITATION OF LIABILITY IS CUMULATIVE WITH ALL AMOUNTS PAID TO ANY RELEASED PARTIES BEING AGGREGATED TO DETERMINE SATISFACTION OF THE LIMIT AND APPLIES TO ALL CAUSES OF ACTION IN THE AGGREGATE (WHETHER IN TORT, CONTRACT OR OTHERWISE). I RELEASE THE RELEASED PARTIES FROM ALL OBLIGATIONS, LIABILITY, CLAIMS OR DEMANDS IN EXCESS OF THE LIMITATION.

If any provision of this Agreement shall be adjudged illegal, invalid or unenforceable, the balance of the Agreement shall remain in full force and effect. This Agreement shall be construed and governed under North Carolina law. Any action or lawsuit arising out of or related to Training, Services, and/or this Agreement shall be exclusively brought in state or federal courts located in Mecklenburg County, North Carolina.

I have read this Agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily. I acknowledge that I have received valuable consideration in relation to my execution of this Agreement, which I understand to be a prerequisite to my receipt of Services. Finally, I understand that this Agreement shall be of full force and effect as to any and all Services I receive from the Released Parties, without regard to the date or timing of such Services.

Participant Name:_____	Participant Signature: _____	Date: _____

Complete the information below if the Participant is a Minor (under the age of 18):

I, as the parent and/or legal guardian of _____ (Participant Name) ("Participant"), make all of the above waivers and claims on behalf of the Participant.

Parent/Legal Guardian Name:_____	Parent/Legal Guardian Signature: _____	Date: _____

ENTIRE PAGE NEEDS TO BE COMPLETE

PARTICIPANT MEDICAL HISTORY

Name: _____ **DOB:** _____ **DATE:** _____

Do you smoke? ☐YES ☐NO
Do you drink alcohol? ☐YES ☐NO
Are you latex sensitive? ☐YES ☐NO

Are you pregnant or nursing? ☐YES ☐NO
Do you have children? ☐YES ☐NO

PAST MEDICAL/SURGICAL HISTORY:
OPERATIONS: List and indicate operations within the past 5 to 7 years and the approximate year:

_____

Have you had physical therapy before? If yes, please explain: _____
HOSPITALIZATIONS: List and indicate hospitalizations within the past 5 to 7 years and nature of illness:

_____

PRIOR MEDICAL CARE FOR CURRENT EPISODE: _____
PLEASE INDICATE CURRENT LEVEL OF SOCIAL SUPPORT (MARRIED, CHILDREN ETC.): _____
AT THE PRESENT TIME WOULD YOU SAY YOUR HEALTH IS: (circle one) **EXCELLENT VERY GOOD FAIR POOR**

GENERAL HEALTH AT THIS TIME:

Fever	☐Yes	☐No
Chills	☐Yes	☐No
Fatigue or Tiredness	☐Yes	☐No
Cancer	☐Yes	☐No
Unexplained weight loss or gain	☐Yes	☐No
Blurred Vision	☐Yes	☐No
Double Vision	☐Yes	☐No
Blindness	☐Yes	☐No

CARDIOVASCULAR

Heart Trouble	☐Yes	☐No
Chest Pain	☐Yes	☐No
Irregular or Fast Heartbeat	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Pacemaker	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Coughing	☐Yes	☐No

ENDOCRINE

Diabetes	☐Yes	☐No
Heat/Cold Intolerance	☐Yes	☐No

PSYCHIATRIC

Nervousness	☐Yes	☐No
Depression	☐Yes	☐No
Insomnia	☐Yes	☐No

GASTROINTESTINAL

Nausea/Vomiting	☐Yes	☐No
Frequent Diarrhea	☐Yes	☐No
Rectal Bleeding/Blood in stool	☐Yes	☐No
Abdominal Pain/Heartburn	☐Yes	☐No
Peptic or Stomach Ulcers	☐Yes	☐No

MUSCULOSKELETAL

Joint Pain	☐Yes	☐No
Muscle Pain	☐Yes	☐No
Muscle Weakness	☐Yes	☐No
Joint Stiffness/Cramping/Gout	☐Yes	☐No
Arthritis	☐Yes	☐No
Recent Fractures	☐Yes	☐No
Metal Implants	☐Yes	☐No
Recent Falls	☐Yes	☐No

NEUROLOGICAL

Stroke	☐Yes	☐No
Frequent Headaches	☐Yes	☐No
Lightheadedness/Dizziness	☐Yes	☐No
Seizures	☐Yes	☐No
Numbness/Tingling	☐Yes	☐No
Tremors	☐Yes	☐No
Head Injury	☐Yes	☐No
Blackout/Loss of Consciousness	☐Yes	☐NO

ENTIRE PAGE NEEDS TO BE COMPLETE

Photography, Filming, Videotaping Consent

I, _____, give my permission to be photographed, filmed
(Participant Name)
and/or recorded as described below.

- I understand that the photograph(s), film(s) or other recording(s) may be used for the following purposes: social media, such as Facebook, Instagram, and Twitter.
- I understand that I may refuse to sign this form. My refusal to sign will not affect my ability to receive performance services.
- I understand that I may cancel my permission in writing at any time at or before the recording, film or image is used.
- I have read and understand this information.
- I am the participant or am permitted to act on behalf of the participant to sign this document. My signature verifies permission to photograph, film or record under the above stated terms.

_____
Participant's Signature Date/Time

_____ _____
Signature of Authorized Person Date/Time Relationship to Participant

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter refused
(Name/number of person/services chosen/used)

NOVANT HEALTH

Photography, Filming, Videotaping Consent

Name / MR # / Label