SPECTRUM HEALTH
Medical Group

Sports Medicine

Athletic Pre-participation Physical Examination

Welcome Letter

Thank you for participating in the Spectrum Health Medical Group Sports Medicine athletic pre-participation physical examination day. This is a complimentary service provided as part of your school's partnership with the Spectrum Health Medical Group Outreach Athletic Training Program. Please check with your athletic office for any specific costs or fees.

Our goal is to provide your son and/or daughter an efficient, cost effective, multi-disciplinary medical examination in order to help ensure greater safety in future athletic participation. While no medical exam can completely eliminate all risks associated with participation in sports, we aim to provide a more thorough physical exam. ***This examination does not and should not take the place of a yearly well-check by your child's health care provider!***

To help ensure a smooth process, we ask that parents and/or guardians complete all required forms accurately and completely. This includes the *MHSAA Physical Examination Form* as well as the *Spectrum Health General Consent Form*. Both of these completed forms **must** accompany your son/daughter on the date of the event. Please note, our staff will be unable to complete the physical exam without parental/guardian signed consent.

Upon completion of the athletic physical examination process, all original copies of the MHSAA Physical Examination Form will be collected by our staff and returned to each school in the week following your child's exam. In the event that your son and/or daughter are *not* cleared for participation as a result of findings during their physical exam, we will contact the identified parent/guardian directly to help provide additional information. In addition, you will receive a copy of the original physical examination form as well as information and resources to help coordinate the recommended follow-up care.

Please contact the athletic department with specific questions or conflicts

SPECTRUM HEALTH
Medical Group

Consent
GENERAL, TREATMENT AND RELEASE OF INFORMATION - MEDICAL GROUP

Patient printed name _____

Medical record number _____ Account number _____ Date _____

NOTICE OF NONDISCRIMINATION:

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Spectrum Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. See pages 3 and 4 for the complete notice of nondiscrimination as well as availability of language assistance.

I AGREE:

- To the care and treatment the doctor and other healthcare professionals have ordered. The doctor may have help from other healthcare professionals.
- That the doctor may change my care to benefit my life or health.
- If I am here to give birth, the doctor and other healthcare professionals may give care to my baby.

I UNDERSTAND THAT:

- I will ask questions.
- No one has made promises about the results of my treatment or care.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- The staff will double-check who I am. They will ask what I am having done. This is to protect me.
- Some doctors and staff are not employees of Spectrum Health. I know that Spectrum Health is not responsible for their care or other actions. I also know I will receive separate bills from them even though they provide services to me at a Spectrum Health location. I will work with their offices to answer questions about my insurance.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- A copy of the Spectrum Health Financial Assistance Eligibility Policy is available upon request at all Registration Areas and on our website at www.spectrumhealth.org.
- Spectrum Health will not tolerate discrimination against my doctor, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.

MY MEDICAL INFORMATION

- SPECTRUM HEALTH MAY RELEASE MY MEDICAL INFORMATION TO:
  - Insurance companies, health plans and administrators for payment of services I receive.
  - Government agencies like Medicare and Medicaid or as required by law.
  - My doctors and others involved in my care now or in the future.
  - My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
  - Any person or entity responsible to pay all or part of my bill.
- I agree that Spectrum Health can take my picture and save it to my electronic medical record. I understand that Spectrum Health will use this picture for identification purposes with the goal of improving my patient experience as I move throughout the Spectrum Health system.
- I understand Spectrum Health will keep my medical information according to State law, Federal law and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes my diagnosis (what is wrong with me), treatments (what we are doing to make me better), and medicine or prescription information about my mental health, infectious diseases like HIV, and other problems like drug or alcohol use may be included.
- In some cases, Spectrum Health is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.

OVER →

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

X14334 (4/17) - Page 1 of 4 © Spectrum Health
(Spanish X14679) (Vietnamese X14681)
(Bosnian X14925) (Burmese X16004)
(Nepali X16034)

X143344

GENERAL, TREATMENT AND RELEASE OF INFORMATION - MEDICAL GROUP *(CONTINUED)*

PRIVACY NOTICE

- I have rights and responsibilities when I receive services. Spectrum Health has given me its Notice of Privacy Practices, and I have had an opportunity to ask questions about the information in the Notice.

VALUABLES

- Spectrum Health would like its patients to leave valuables at home or with family members. I agree Spectrum Health is not responsible for safeguarding my property.

CONSENT TO CALL

- I have provided residential and/or cellular telephone numbers and an email address to Spectrum Health. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from Spectrum Health and/or its agents/third parties at any of these phone numbers for communication including billing purposes. I understand that my consent to call is not a condition of my treatment.

AUTHORIZATION TO RECEIVE PAYMENT

- Spectrum Health is authorized to act on my behalf in the collection of benefits from any third party and in the endorsement of checks payable to me and/or Spectrum Health. I understand that Spectrum Health is authorized to seek payment from any third party and from me.

ASSIGNMENT

- I assign Spectrum Health:
  - All benefits, claims, and any and all other rights, including the right to bill and talk to any third party for the purpose of seeking payment.
  - The right to file suit or intervene in any lawsuit or proceeding which involves my charges at Spectrum Health.
  - The right to take any other action seeking payment of my Spectrum Health charges.
- This assignment includes, but is not limited to, the right to appeal the denial of payment of my Spectrum Health charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract. I authorize Spectrum Health to act on my behalf to pursue an ERISA benefit claim or to appeal an adverse benefit determination. I agree to assist Spectrum Health in the pursuit of all insurance benefits and agree to pay all co-insurance, co-payments and deductibles required by any insurance plan.
- I also assign to Spectrum Health, and agree that I waive, any and all rights to settle, release or retain payment of my Spectrum Health charges, or take any other action which would in any way compromise payment or reimbursement of my Spectrum Health charges.

BILLING

- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay Spectrum Health for the services given. I understand that I am responsible for any charges not covered by insurance.
- I agree that if my account is not paid when due, and the hospital should retain a lawyer and/or collection agency for collection, I will be responsible to reimburse the hospital for all costs, charges and fees associated with the collection of the amount due including, but not limited to, reasonable interest, legal costs in the event suit is filed and reasonable lawyer fees and/or reasonable collection agency fees including those based on a percentage of the debt.

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME _____ ☐AM ☐PM **DATE** _____ Patient signature _____

- Patient is under 18 years of age or otherwise unable to consent because _____

TIME _____ ☐AM ☐PM **DATE** _____ Parent/Legal Guardian/Patient Advocate/Next of Kin signature _____

Printed name _____

STAFF SIGNATURE(S)

TIME _____ ☐AM ☐PM **DATE** _____ Witness _____

SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME _____ ☐AM ☐PM **DATE** _____ Witness _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐AM ☐PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

CONTINUED ON PAGE 3 →

GENERAL, TREATMENT AND RELEASE OF INFORMATION - MEDICAL GROUP *(CONTINUED)*

Patient printed name _____

Medical record number _____ Account number _____ Date _____

NOTICE OF NONDISCRIMINATION:

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Spectrum Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SPECTRUM HEALTH:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Spectrum Health Language Services at 616.267.9701, 1.844.359.1607 (TTY:711).

If you believe that Spectrum Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex:

- You can file a grievance with:
  Director, Patient Experience
  100 Michigan Street NE, MC 006
  Grand Rapids, MI 49503
  616-391-2624 or toll free: 1-855-613-2262
  patient.relations@spectrumhealth.org
  You can file a grievance in person, by mail or by email. If you need help filing a grievance, the Director of Patient Experience is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW, Room 509F, HHH Building
  Washington, DC 20201
  1-800-368-1019 or 800-537-7697 (TDD)
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CONTACT US:

Español (*Spanish*)
ATENCIÓN: Si usted habla español, tiene a sù disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-359-1607 (TTY: 711).

العربية (*Arabic*)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-359-1607 (رقم هاتف الصم والبكم: 711).

中文 (*Chinese*): 國語/普通話 (*Mandarin*), 粵語 (*Cantonese*)
請注意：如果您講中文，你可以獲得免費的語言輔助服務。請撥打 1-844-359-1607（TTY 手語翻譯：711）。

Tiếng Việt (*Vietnamese*)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-359-1607 (TTY: 711).

Ako govorite srpsko *(Serbian, Croatian or Bosnian)*
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-359-1607 (TTY: 711). (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711).

OVER ➔

NOTICE OF NONDISCRIMINATION: *(CONTINUED)*

CONTACT US: *(CONTINUED)*

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-844-359-1607. (መስማት ለተሳናቸው: (TTY: 711).

नेपाली *(Nepali)*
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-359-1607 **(टिटिवाइ:** (TTY: 711).

Thuɔŋjaŋ *(Nilotic – Dinka)*
PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-844-359-1607 (TTY: 711).

Kiswahili *(Swahili)*
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-359-1607 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.844-359-1607 (TTY: 711) **تماس بگیرید.**

Français *(French)*
ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1.844-359-1607 (TTY: 711).

(Burmese)
အသိပေးခြင်း

သင်ပြောသော ဘာသာစကား:ကို အခမဲ့ ဘာသာပြန်
ရှိပါသည်။ ဖုန်းခေါ်ရန်

فارسی دری (Dari)
توجه اگر به زبان دری صحبت می کنید، خدمات کمک زبانی بصورت رایگان برای شما در دسترس است. تماس ب 1-844-359-1607 (TTY: 711).

Kreyòl Ayisyen *(Haitian Creole)*
ATANSYON: Si ou pale Kreyòl Ayisyen, gen èd nan lang ki disponib gratis pou ou. Rele nimewo 1-844-359-1607 (TTY: 711).

Ikinyarwanda *(Kinyarwanda)*
ICYITONDERWA: Niba uvuga ikinyarwanda, serivisi z'ubufasha ku byerekeye ururimi, urazihabwa, ku buntu.
Hamagara 1-844-359-1607 (ABAFITE UBUMUGA BW'AMATWI BIFASHISHA ICYUMA CYANDIKA -TTY: 711).

Soomaali *(Somali)*
DIGTOONI: Haddii aad hadasho Soomaali, adeegyada caawimada luqadda, oo bilaasha, ayaad heli kartaa. Wac 1.844-359-1607 (TTY: 711).

اللهجة السودانية *(**Sudanese**)*
انتباه: إذا كنت تتحدّث اللهجة السودانية، خدمات المساعدة بلغتك متاحة مجاناً. اتصل على الأرقام 1-844-359-1607 **(رقم الصم والبكم: 711).**

தமிழ் *(Tamil)*
கவனம்: நீங்கள் தமிழ் பேசினால், உங்களுக்கு இலவசமான மொழி உதவிச் சேவைகள் கிடைக்கின்றன.இந்த எண்ணை அழைக்கவும்: 1-844-359-1607 (TTY: 711).

ትግርኛ (Tigrinya)
ትሸፈት: ትግርኛ እንደሕር ትዛረብኮንካ፣ ናይቋንቋ ደገፍ ኣልግሎታት፣ ብናጻ ክቐርበልካ እየም። ደዉል 1.844-359-1607 (TTY: 711)።