HSHS Athletes Advantage Sports Medicine

CONSENT FOR TREATMENT
ImPACT® Concussion Test™

Medical Consent

I request and authorize HSHS St. Joseph's Hospital colleagues and agents, to administer neurocognitive function diagnostic tests utilizing the ImPACT® Concussion Test™, a third party software product licensed by ImPACT to HSHS St. Joseph's Hospital and administered online. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made as to the result of such testing at HSHS St. Joseph's Hospital and I have been reasonably informed of any risks and possible consequences involved and that unforeseen results may occur.

I understand that the ImPACT® Concussion Test™ is administered online and that if the patient is thirteen (13) years of age or younger, certain requirements of the Children's Online Privacy Protection Rule ("COPPA") may apply. In accordance with such COPPA requirements, if applicable, the patient's representative hereby authorizes HSHS St. Joseph's Hospital to collect, use, and disclose personal information of the patient as permitted by this agreement.

I understand that any patient information and data provided to ImPACT through the testing process, and any data created as a result of the testing process, are stored by ImPACT, a third party provider, and that as such, HSHS St. Joseph's Hospital shall not be liable for any loss, theft or destruction of such information or data stored by ImPACT.

Patient/Authorized Representative

HSHS St. Joseph's Hospital and the patient or patient's representative hereby enter into this agreement. The patient or patient's representative certifies that he/she has read, understood, and accepted the above statements, that he/she is the patient or is duly authorized on behalf of the patient to execute such an agreement and executes this agreement voluntarily. I have read the terms and conditions cited above. This form has been explained to me and I understand its contents and significance.

_____
Patient Name

_____
Signature Relationship (if patient is a minor or unable to sign) Date

_____
Witness Date

HSHS Athletes Advantage Sports Medicine

AUTHORIZATION
ImPACT® Concussion Test™

Release of Information

I authorize HSHS St. Joseph's Hospital to release information pertaining to my testing, diagnoses and treatment to insurance carrier(s) or other parties who are or may be liable for all or part of the charges and their agents responsible for precertification for the purpose of verification and/or collection of payment for my care. This consent for release of information is subject to revocation at any time except to the extent that the action has already been taken. This consent expires upon satisfaction of my claim for benefits. I understand that I have the right to inspect and copy the information that would result in possible denial of insurance reimbursement.

I authorize HSHS St. Joseph's Hospital to obtain or release to ImPACT, other medical facilities, physicians, insurance companies or other third party payers, medical information on myself, including but not limited to patient information and data provided through the ImPACT testing process, and any data created as a result of the testing process, for the purpose of diagnosis or treatment of my medical condition and the processing of bills to insurance companies.

I authorize HSHS St. Joseph's Hospital during and after I received healthcare services at HSHS St. Joseph's Hospital to discuss all aspects of my condition, treatment, and the contents of my records with HSHS St. Joseph's Hospital administrative staff and colleagues, agents and independent contractors as well as HSHS St. Joseph's Hospital's authorized representatives including but not limited to, such individuals involved in peer review, quality assurance, utilization review, accreditation, licensure, risk management, and with the hospital's legal counsel. I understand that these discussions are for peer review, quality assurance, hospital administration, utilization review, risk management, complaint resolution, litigation, healthcare operations, and other hospital purposes. I also understand this authorization is not a condition of my treatment.

Unless otherwise specified herein, this authorization will expire ten (10) years after the date below or sooner by my revocation. I understand I may revoke this authorization at any time. Revocation must be made in writing and sent to HSHS St. Joseph's Hospital, 12866 Troxler Avenue, Highland, IL 62249, Attention: Rehab/Sports Medicine. Revocation will not affect any action HSHS St. Joseph's Hospital took in reliance on this authorization prior to revocation.

I will receive no compensation for authorization for the release of this information. HSHS St. Joseph's Hospital will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization form. The information used or disclosed may be subject to redisclosure by the person or entity receiving such information and thus is no longer protected by the federal privacy regulations.

I have read this authorization, fully understand its contents, and agree to be bound by its terms. I acknowledge and represent I am 18 years of age or older and have the right to contract in my own name or that I am legally authorized to sign for the patient named below.

_____
Patient Name

_____
Signature Relationship Date
(if patient is a minor or unable to sign)