MedicalArt Resources INC.

ATHLETIC FACEGUARD REGISTRATION INFORMATION

Personal Information

Athlete's Name: | Birth Date: | Home Phone:

Address: | Work Phone: | Cell Phone:

City State Zip: | Email:

Parent/Guardian Name (for minor athlete): | Work Phone: | Cell Phone:

Emergency Contact: | Phone:

Medical Information

Location of fracture/injury:

Date of traumatic injury or surgery: | Sport played:

Referring Physician Name: | Phone:

Address: | City, State, Zip:

Type of faceguard: Raptor ☐ Transparent (clear) ☐

Consent for Treatment:
I, the undersigned, request evaluation for a custom athletic faceguard as of this date. If I decide to proceed with design and fabrication of the faceguard I agree to provide a physician's order prior to treatment. **I fully understand that the face guard provides the athlete only limited protection from additional injury.**

Signature of Athlete or Legal Representative / Date

Milwaukee Office
3400 S 103rd Street, Suite 200
Milwaukee, WI 53227

p: (414) 543-1002
f: (414) 543-0137
www.medicalartresources.com

Madison Office
406 Science Drive, Suite 402
Madison, WI 53711

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Medical Art Resources, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used in treatment, payment or health care operations.
- Medical Art Resources, Inc. has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Medical Art Resources, Inc. reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Medical Art Resources, Inc. does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.
- Medical Art Resources, Inc. may condition receipt of services upon execution of this consent.

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL AND FINANCIAL INFORMATION WITH ANOTHER PERSON OR ENTITY?

☐ NO

☐ YES, MEDICAL INFORMATION ONLY

☐ YES, FINANCIAL INFORMATION ONLY

☐ YES, MEDICAL AND FINANCIAL INFORMATION

If yes, please provide their name, relationship, and phone number.

Name:_____Relationship:_____

Phone number:_____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE OR VOICEMAIL?

☐ YES ☐ NO If yes, phone number(s):_____

THIS CONSENT WAS SIGNED BY:

_____

Signature of Patient or Legal Representative / Date

_____

Printed name Legal Representative if other than Patient / Date

Milwaukee Office
3400 S 103rd Street, Suite 200
Milwaukee, WI 53227

p: (414) 543-1002
f: (414) 543-0137
www.medicalartresources.com

Madison Office
406 Science Drive, Suite 402
Madison, WI 53711