CEMR
CENTER *for* EXERCISE MEDICINE & REHABILITATION
VALDOSTA STATE UNIVERSITY

Patient Registration Form

Personal Information

Name: _____ Name you prefer: _____

Home Address: _____ Apt # _____

City: _____ State:_____ Zip Code: _____

Best Phone Number: _____ Date of Birth: _____/_____/_____ Age: _____

Email: _____

Emergency Contact:

Name: _____ Relationship: _____

Emergency Contact Phone#: _____

Referral Information:

Injury/Diagnosis: _____

Date of Injury/Onset of Symptoms: _____

Referring Physician Name: _____ City/State: _____

How did you hear about the Center for Exercise Medicine and Rehabilitation? _____

_____

Patient/Parent Name Signature Date

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Medical History

Patient Name: _____ Date: _____

1. Do you now have or have you had the following?

   - Stroke Yes ◯ No ◯ Explain _____
   - Heart Disease/Murmur Yes ◯ No ◯ Explain _____
   - High Blood Pressure Yes ◯ No ◯ Explain _____
   - Asthma Yes ◯ No ◯ Explain _____
   - Diabetes Yes ◯ No ◯ Explain _____
   - Epilepsy/Fainting Yes ◯ No ◯ Explain _____
   - Impaired Vision/Hearing Yes ◯ No ◯ Explain _____
   - Cancer Yes ◯ No ◯ Explain _____
   - Drug Allergies Yes ◯ No ◯ Explain _____
   - Osteoporosis Yes ◯ No ◯ Explain _____

2. What is the overall pain rating for your current condition using a scale of 0 to 10? _____/10
3. Have you sprained, strained, dislocated, or fractured any of the following:
   - Neck/Head (including concussion) Yes ◯ No ◯ _____
   - Trunk (ribs, vertebrae, sternum) Yes ◯ No ◯ _____
   - Low Back (vertebrae, discs, nerves) Yes ◯ No ◯ _____
   - Upper Extremity (shoulder, elbow wrist, arm) Yes ◯ No ◯ _____
   - Lower Extremity (hip, leg, knee, ankle, foot) Yes ◯ No ◯ _____
4. Please list any surgeries that you have had and the dates: _____
   _____
5. Please list any medications that you are taking: _____
   _____
6. Women: Are you pregnant? Yes ◯ No ◯
7. Have you ever received treatment or rehabilitation? Yes ◯ No ◯
   If so, When? _____

I agree that the above information is accurate and should anything change, I will immediately notify a CEMR staff member.

_____

Patient/Guardian Date

Revised 9/20

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Informed Consent for Evaluation, Treatment, and Rehabilitation

Consent to Treatment: I voluntarily authorize the rendering of such care, including diagnostic and medical treatment by authorized agents and employees of Valdosta State University Center for Exercise Medicine and Rehabilitation (CEMR) or their designees, as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical procedures. *I understand that all care will be provided or supervised by a licensed athletic trainer*.

Release of Information: I authorize the release of my medical records or the records of the person for whom I am duly authorized to do so, as may be required by:

- Any health, sickness, and/or accident insurance carrier, workman's compensation, or agency (social, welfare, governmental) which is legally responsible, or which VSU has good cause to believe is legally responsible for all or any part of the CEMR charges and/or professional fees.
- Physicians or health care facilities rendering or evaluating the patient for professional care.
- Any information that is not personally identifiable with me for research and statistical purposes so long as it does not identify me or provide facts that could lead to my identification.

This consent may be revoked at any time, except to the extent that action has already been taken by the patient/duly authorized agent.

Guarantee of Payment: I agree to be responsible to Valdosta State University CEMR for charges resulting from services rendered at their prevailing rates and not covered by insurance. I understand that Student Health Fees do not cover the services of CEMR for VSU students.

No Show Policy: If an appointment must be cancelled, a 24-hour notice is preferred. If a cancelation is necessary, please contact the office to reschedule the appointment or reschedule it online through the CEMR website (www.valdosta.edu/cemr). If a cancellation is made without 24-hour notice or an appointment is missed, *you may be charged the full amount for the missed appointment.*

Patients who miss 3 consecutive appointments may be discharged and a new referral will be necessary to resume the rehabilitation program.

_____ _____

Patient's Signature Date

_____

Parent/Guardian's Signature (if patient under 18)

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ATHLETIC TRAINING CLINIC

AGREEMENT AND RELEASE OF LIABILITY

1. In consideration of being allowed to participate in the activities and programs of *Valdosta State University – Center for Exercise Medicine and Rehabilitation Athletic Training Clinic* and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge The Board of Regents of the University System of Georgia by and on behalf of *Valdosta State University* and it officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also herby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of *Valdosta State University - Athletic Training* Clinic or the use of any equipment at *Valdosta State University - Athletic Training Clinic*.

2. I understand and am aware that strength, flexibility, aerobic exercise, therapeutic exercise, the use of therapeutic modalities, and the use of equipment, are potentially hazardous activities. I also understand that physical activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

Date: _____ Signature: _____

Parent/Guardian Signature (If patient under 18): _____

American College of Sports Medicine (2012). *ACSM's Health/Fitness Facility Standards and Guidelines*, 4th edition. Human Kinetics; Champaign, IL

Ray, R. Konin, J. (2011). Management Strategies in Athletic Training. 4th edition. Human Kinetics; Champaign, IL.

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TREATMENT AND REHABILITATION
Notice of Privacy Practices

I authorize that I am aware of my rights according to HIPPA and my Protected Health Information. The *Valdosta State University: Center for Exercise Medicine & Rehabilitation* has offered me a copy of their Notice of Privacy Practices for my records.

If there is anyone that you would like to authorize the disclosure of your Protected Health Information, please name the party below.

Patient/Parent Name Signature Date

Thank you for your continued support of VSU and the Center for Exercise Medicine and Rehabilitation!