SPORTS MEDICINE INSTITUTE

Performance, Prevention, Rehabilitation

Name:_____ **Gender: M**____ **F**____

Address: _____

Street **City** **State** **Zip**

Parent's Address (Student Only):

_____

Phone Numbers:

Work: _____ **Occupation:** _____

Home: _____ **Employer:**_____

Cell: _____ **Birth date:**_____

E-mail Address: _____

Who referred you to this office?_____ **Relationship:**_____

In emergency notify: _____ **Phone:**_____

TAX DEDUCTIBLE CONTRIBUTIONS

SMI is a Public Benefit Non-Profit 501(c) 3 Corporation. We are dedicated to the prevention and treatment of overuse injuries, optimization of human function and enhancement of athletic performance. Through education, research and charitable services we help active individuals and athletes of all abilities maximize their potential and function at the highest level possible.
We conduct a number of community outreach programs such as the *Support a Future Olympian Program* and the *From our Feet Shoe Donation Program*. We are constantly looking for donations to help subsidize these programs. If you are interested in making a donation or have any questions regarding any of the community outreach programs please contact **Mark Fadil at 650-322-2809 x315**. Thank you for your support!

PAYMENT & 24 HOUR CANCELLATION POLICY

Please pay with CASH, CHECK, VISA or MASTERCARD at the end of each visit. If you carry a balance for at least 90 days the bill will be sent to a collection agency and you will be charged an additional fee to cover the cost of the collections agency.
If you cancel your appointment within **24 hours** of the scheduled time or miss the appointment, you will be charged the full cost of the session.

Signature:_____ **Date:**_____

COMPETING ATHLETES

Ask your therapist for an Application for *Beneficiary Status* if you are a competing athlete and cannot afford to pay the regular rate. Please do not apply for beneficiary status if you can afford the regular rate. This deprives someone else who is in a less fortunate circumstance from getting lower cost services.

FOR SMI USE ONLY

Category: R T I H G F E D C B A

Last Updated: _____

Group Account: Stanford Track and Field Stanford Men's Swimming Farm Team

ORTHOPEDIC MASSAGE THERAPY

Current Musculoskeletal Complain, injury or Diagnosis: _____

Describe the problem in detail: _____

_____

When did it start? Gradual or sudden onset? _____

_____

Is it getting better? Worse? Not changing?_____

Can you perform your sport/activity? _____

What other injuries or problems have you previously had and when? _____

_____

Have you seen a Physician? _____

If yes, who? _____

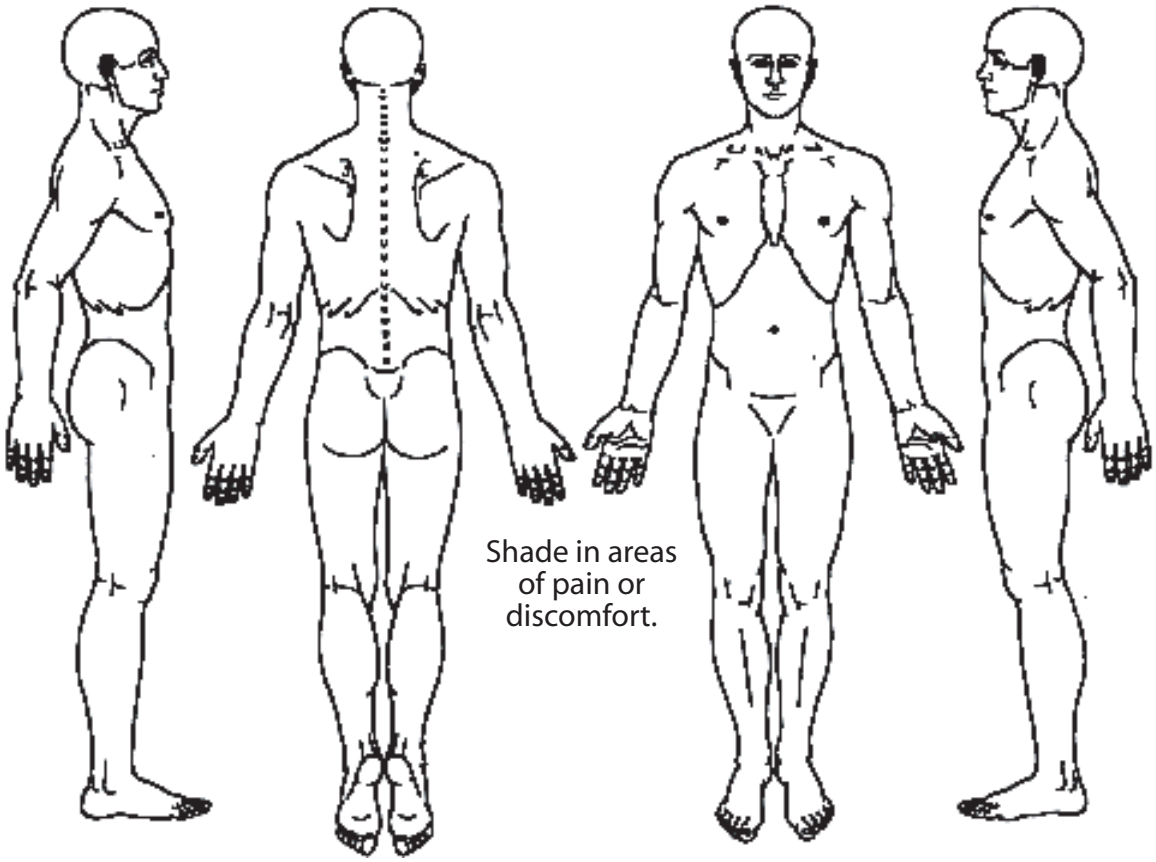
What other types of treatment have you undergone? _____

Have they helped? _____

Other Information: _____

_____

_____



24hr. Cancellation Policy Agreement

SMI requires 24 hour notice in the event of a cancellation. There is a **FULL** service fee for no-show or cancellation without 24hr prior notification. This charge will not be covered by insurance.

By reading this statement, ***I hereby authorize SMI to charge my credit card for any appointment missed without proper notification:***

Credit Card#:_____

Expiration Date: _____/_____ CVV:

Signature: _____

SMI accepts: **VISA MASTER CARD & DISCOVER ONLY**