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? _____

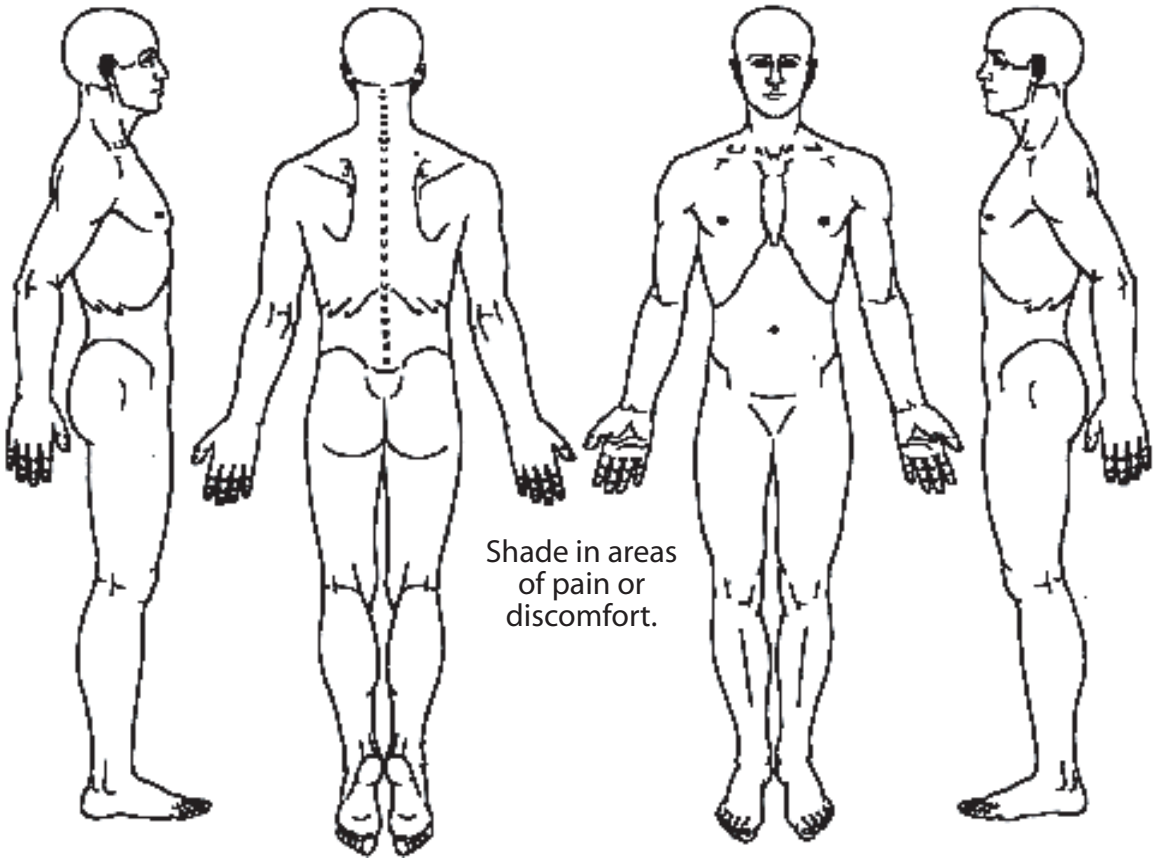
What other types of treatment have you undergone? _____

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**

Sports Medicine Institute

Medical History Form

1. Y ☐ N ☐ Are you pregnant? _____

2. Y ☐ N ☐ Do you have high blood pressure? If yes, is it under control?_____

_____

3. Y ☐ N ☐ Do you suffer from seizure disorders or epilepsy?_____

_____

4. Y ☐ N ☐ Have you broken any bones in the past two years? Which?_____

_____

5. Y ☐ N ☐ Do you have cardiac or circulatory problems? Please explain?_____

_____

6. Y ☐ N ☐ Have you ever had surgery? If yes, please explain?_____

_____

7. Y ☐ N ☐ Do you have any other medical conditions or injuries?_____

_____

_____

_____

8. Y ☐ N ☐ Are you currently taking any medications? What for?_____

_____

_____

_____

9. Y ☐ N ☐ Are you allergic or sensitive to any oils (palm oil, bees wax,)? if yes, please list.

_____

10. Any additional medical information:_____

_____

_____

_____

_____

_____

Sports Medicine Institute

Massage Client Waiver Form

Please take a moment to read and initial the following information:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

_____

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____

I affirm that I have notified my therapist of all known medical conditions and injuries.

_____

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

_____

I understand that massage is entirely therapeutic and non-sexual in nature.

_____

By signing this release, I hereby waive and release my therapist, Sports Medicine Institute (SMI), & Peak Physical Therapy from any and all liability, past, present, and future relating to treatment.

_____

Client Name:_____ Date:_____/_____/_____

Please Print

Client Signature:_____

Sports Medicine Institute

Informed Consent to Orthopedic Massage Therapy Treatment

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name: _____ Date:____/____/____
PLEASE PRINT

Signature:_____

Parent or Guardian
(if under 18yrs of age): _____ Date:____/____/____
PLEASE PRINT

Signature:_____