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 & 48 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 **48 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? _____

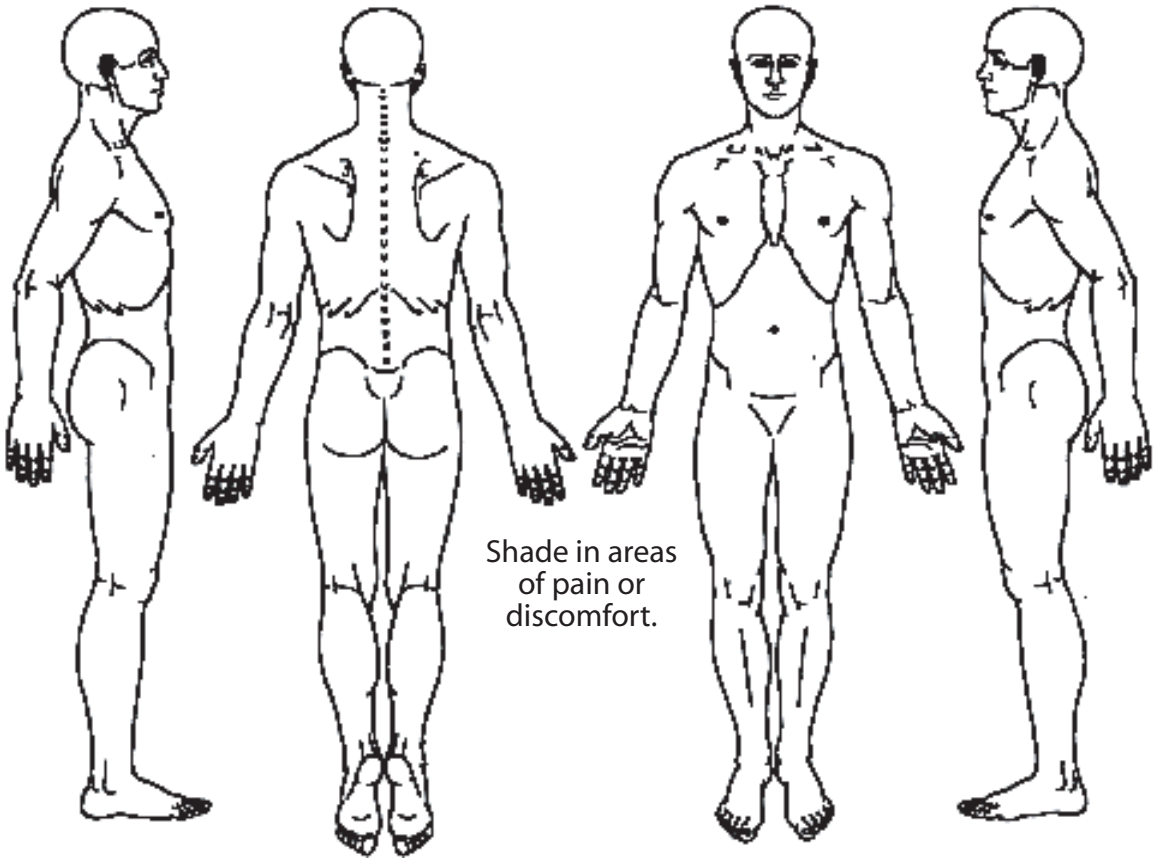
What other types of treatment have you undergone? _____

Have they helped? _____

Other Information: _____

_____

_____



48hr. Cancellation Policy Agreement

SMI requires 48 hour notice in the event of a cancellation. There is a **FULL** service fee for no-show or cancellation without 48hr 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 <u>ONLY</u>**

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:_____

260 Sheridan Avenue, Suite B40
Palo Alto, CA 94306
(650) 322-2809 | www.smiweb.org

SMI
SPORTS MEDICINE INSTITUTE

CHIROPRACTIC INFORMED CONSENT

For Diagnosis and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Catherine Ryan, D.C.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, the doctor originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

_____
Patient Name (Please Print)

_____ _____/_____/20_____
Signature of Patient or Guardian Date

_____ _____/_____/20_____
Signature of Witness Date

_____, D.C. _____/_____/20_____
Signature of Dr. Catherine Ryan, D.C. Date