Eric J. Freitag, Psy.D.
Program Director
Credentialed ImPACT Consultant

www.sportconcussion.com

Informed Consent for Testing/Treatment

Dear Parents and Athletes,

Welcome to the Sport Concussion Program. So that you may be fully informed about the services you are receiving, please take the time to read the enclosed information about this program. If you should have additional questions, please visit our website www.sportconcussion.com or contact Dr. Freitag at drfreitag@sportconcussion.com or (925) 988-0569.

The Baseline Testing and Post Concussion Screenings involve tasks that measure brain-behavior relationships. This is neither intelligence nor achievement testing. This testing is not diagnostic. No invasive procedures are performed. The scores from the testing will be kept on file. There will be no feedback or report generated for baseline testing unless one is requested for other purposes, at an additional charge. These test results will be kept confidential and will be released only with your written consent. We are not aware of any risks associated with participating in baseline testing or post- concussion screening. Baseline (ImPACT) testing is for athletes 10 years of age or older.

Any baseline testing or post concussion screening performed is not a full cognitive or neuropsychological test battery. **You understand that a brief screening may not be as reliable nor as accurate as a full test battery in detecting neuropsychological or brain dysfunction or learning/memory disorders.** If you prefer a full neuropsychological battery, you should discuss this with the program director. Full neuropsychological evaluation is available at an additional charge or through a referral. You understand that the results of this baseline for youth athletes may not be valid for an extended period of time because of maturation and brain development and should be updated every 1-2 years.

The major purpose of baseline testing is to help establish an idea of the athlete's present functioning so that if at a later date the athlete sustains a concussion, he/she can be retested to assist in medical decision-making, such as readiness to return to play, need for treatment, and the possibility of brain injury. You understand that in cases of concussion or head injury, testing beyond the basic repetition of the ImPACT (baseline) testing may be recommended or needed to determine full extent of brain injury. If it is determined that the athlete requires a full neuropsychological evaluation and/or treatment at that time, we can assist you in making those arrangements. Some athletes will be requested to re-take an invalid baseline test. This will be done at no additional charge. The program will contact each individual parent to provide details on re-testing as necessary.

The fee for baseline testing is $40 (group testing [8+] may be at a reduced rate). This amount shall be paid to the Mt. Diablo Memory Center. Post injury testing will be administered as outlined in the document "Explanation of services and Care Protocol". Since baseline testing should be performed on healthy athletes, please advise the onsite proctor if you have sustained a head injury within the last two months, are sick or ill (e.g. flu), or taking medications which may affect your cognitive functioning (e.g. cold medicine).

You understand that if you sustain a concussion, you should immediately tell your coach, athletic trainer and physician. Your coach and/or school may condition your return to participation on the approval of your physician, athletic trainer, and Sport Concussion Program clinician. Their decision may be made, in part, based on the results of performance and involvement in the Sport Concussion Program. **You understand that if Dr. Freitag makes a determination that advises against a return to play and the athlete subsequently does return to play, than Dr. Freitag reserves the right to discontinue treatment or care with that athlete. You agree to give Dr. Freitag and/or the Sport Concussion Program permission to discuss your medical condition with the professionals involved in your care, such as the athletic director, coaches, trainers, EMTs, doctors, nurses, etc..**

1940 Tice Valley Blvd. Suite C
Walnut Creek CA 94595

Phone: (925) 988-0569
Fax: (925) 478-7930

We would like you to be aware of your right to confidentiality and our commitment to safeguard that right. The patient-clinician relationship is a confidential and privileged one, and is thus protected by law and ethical code. However, there may be limits to confidentiality depending on your particular circumstance. For example, personal injury, worker's compensation, and other legal/court situations may override confidentiality. In cases in which there is a clear risk of harm to self or others or of suspected child abuse, confidentiality is limited by law. Also, we as health care professionals in this practice work as a team and may consult with one another in an effort to enhance your treatment. Please be aware that we also reserve the right to discuss your case with another expert health professional, who may not be part of practice, if we believe that such a consultation would benefit your care.

If you have been referred for neuropsychological or psychological testing, the neuropsychologist will assess the extent and type of testing that will be most useful in answering the diagnostic question. This may be done before or at the time of the first appointment, or as testing unfolds, depending on the nature of the case.

Regarding billing for post injury care, payment in full is due at the time the service is rendered unless other arrangements have been made. Information regarding fees is outlined in the "Explanation of Services" document. We reserve the right to charge an interest charge of 1 ½% per month (18% per annual percentage rate) on accounts that are greater than 30 days overdue. There is also a returned check fee. Please note that in cases in which the account has been neglected by the patient and there has been no show of good faith by the patient despite our repeated attempts toward resolution, we reserve the right to turn the account over to a collection agency. In hardship circumstances, we are available to discuss payment arrangements.

There may be times when you may receive a mailing from our office, such as an appointment confirmation, notice, bill, report, or other communication. Our mailing envelopes display our practice's name and address. If this is of concern to you, please inform our office staff in writing immediately and we will make other arrangements for mailing.

Our clinicians are available by telephone at times other than your scheduled appointment, if there is a matter that cannot wait until the next appointment. For any telephone calls which last fifteen minutes or longer, we reserve the right to charge you a fee proportionate to our regular examination rate. If you have an emergency, and you call after regular business hours or cannot reach your clinician, please call emergency services at 911 or go to your local hospital emergency room immediately.

We reserve the right to charge you for any missed appointments, or appointments that are canceled with less than 24 hours notice. In the case of a bona fide emergency, the charge will be waived.
We are not responsible for your insurance or health care coverage. We strongly encourage you to clarify the extent of any coverage with your carrier. Please be advised that what your insurance provider/representative says over the phone to either you or to our office staff may not always be correct or clear. As a courtesy to our patients, we may bill your insurance carrier for you and reimbursement for services will be made directly to you. Ultimately, you are responsible for payment of the services rendered to you.

PLEASE KEEP THE INFORMATION ABOVE AND SIGN AND DATE THE FORM ON THE NEXT PAGE ACKNOWLEDGING RECEIPT. PLEASE TURN IN THE SIGNATURE FORM TO THE EXAM PROCTOR AT THE TIME OF TESTING.

After you have read the Informed Consent for Treatment form, please sign your name and the date below indicating that you have understood and accepted what you have read. <u>If there is a custody/guardian or other legal arrangement which requires the signature of more than one party for a minor to receive services, you agree to take full responsibility to immediately secure the signatures of all necessary parties below before testing or treatment.</u>

_____ _____
Signature of Patient if age 14 or over PRINT PATIENT NAME ABOVE

_____
School

_____ _____
Signature of Parent or Sole Legal Guardian if Patient is under 18 years of age Date

_____ _____
Signature of Other Parent if joint custody of Minor Date

_____
Printed Parent Name

_____
Address

_____
Phone

_____
Email

☐ Please check here if you would like to receive email communication from the Sport Concussion Program (e.g. upcoming baseline testing clinic dates, presentation) Your information will not be shared with a third party.