Parents,

Welcome to another year of exciting athletic events! I would like to take this opportunity to introduce myself and the Northwestern Health Sciences University Human Performance Center. My name is Dr. Melissa MacDonald. I am a Doctor of Chiropractic and Emergency Medical Technician, currently the Integrative Sports Care Coordinator in the Human Performance Center under the supervision of Dr. Andy Klein. This will be our seventh year working with Concordia Academy. Our two residents, Drs. Jaime Ayuso and Shiloh Heesch, will be providing care over this upcoming school year.

The clinic will be available to students on campus twice a week; Mondays and Thursdays, from 2:00-5:00PM, and will be accompanied by one or more student interns with an interest in sports medicine. Our goal is to get your child competing at their best, and to provide exceptional healthcare when needed. The care we will provide is as follows:

- Performing functional and focused examinations on an area of injury
- Diagnose and create a treatment plan for injury recovery
- Provide primary sports care, including chiropractic services, to those who areevaluated and warrant care
- Providing concussion return to play and return to academics

At times, there may be conditions that require more resources and time than can be appointed to them at the Concordia Academy clinic. Due to our partnership with Concordia Academy students, staff, and faculty of Concordia Academy may be seen in our Integrative Clinic and receive chiropractic, rehabilitation, Acupuncture and Chinese Medicine, and massage therapy at Northwestern Health Sciences University without being charged unless advance testing such as X-Ray, MRI, or lab testing is needed. We may contact you asking to see your child in our primary clinic location, or feel free to reach out at the information below to set up an appointment if it's of interest to you.

Even if you have a primary chiropractic, primary care provider, or visit a medical clinic due to aninjury we are happy to co-manage and assist in your student's care in any way you wish! We are here to serve the students and provide an educational environment for our interns to become phenomenal sports care providers. Please let us know if we can be of any assistance.

We are excited to offer a new service this year of telehealth nutrition counseling with our restirred dietitian, Paige.Prestigiacomo. She wil be offering individual 1 v 1 nutrition services for athletes. This will include analyzing individual fueling requirements, pre-and post workout fueling tips, tournament and game day fueling plans, hydration recommendations, supplement quality checks, and Parent grocery store and meal planning ideas. Appointments can be in person on Tuesday nights during Teams clinic at NWHSU, or set up a virtual appointment at a different time.

If you need to get a hold of us, my contact information is provided below. If unavailablefor any reason, feel free to leave a message and we will get back to you as soon as possible.

We look forward to working with all of the athletes and providing them with the care they need toget back on the field quickly and have a successful athletic year!

Sincerely,

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Email: mmacdonald@nwhealth.edu

Jaime Ayuso DC CCSP NREMT
Chiropractic Sport Resident, Third Year
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Shiloh Heesch DC
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Paige Prestigiacomo RDN LDN
Sports Nutrition Resident, Second Year
Email: pprestigiacomo@nwhealth.edu

NORTHWESTERN HEALTH SCIENCES UNIVERSITY
Human Performance Center

INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).
I understand that the treatment I receive at this clinic will either be performed by advanced chiropractic interns under the supervision of a licensed Doctor of Chiropractic or a licensed chiropractor. I also understand that this is a teaching clinic and that student observers may be present during treatment.
I understand that some designated public health issues may have a long incubation period during which time the carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given current limitations in virus testing. Chiropractic procedures present the possibility of spreading the designated public health virus which can linger in the air for unknown periods of time, regardless of the highest sanitation procedures being followed.
By receiving in-person Chiropractic treatment, due to the frequency of visits of other patients, the characteristics of the designated public health issue, and the nature of treatment, I have an elevated risk of contracting the virus simply by being in a chiropractic office. Visits should be limited to the treatment of issues which necessitate an in-person visit based on my clinician's best judgment.
Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks:**

Temporary soreness, increased symptoms or bruising. It is not uncommon for patients to experience temporary soreness, increased symptoms, pain or bruising.

Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan may be modified to minimize risk of fracture.

Disc herniation Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat. Additionally, exercises may be incorporated into an individual's treatment plan. The intensity level of the exercises you are given will be based upon your overall cardiovascular, respiratory, and musculoskeletal health. Please notify your supervisor or intern immediately if you begin to have abnormal shortness of breath, fatigue, chest discomfort, or other prevailing symptoms appear. Possible side effects may include: fatigue, muscle soreness, muscular injury, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, heart attack, and/or stroke.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. 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.

Standard primary sports care will be delivered at Concordia Academy by signing this document. Primary sports care includes taping, triage, ice, heat, ultrasound, and injury rehabilitation. Additionally,

Please initial below

_____(Initial Print) I elect to have my child receive chiropractic service in addition to standard primary sports care

_____(Initial Print) I do not elect to have my child receive chiropractic service in addition to standard primary sports care

PATIENT'S NAME (Print)_____ **DATE OF BIRTH**_____

_____ _____

(PATIENT | GUARDIAN SIGNATURE) **(DATE)**

• CONSENT TO TREATMENT OF A MINOR •

I, _____ , the parent/guardian having legal custody/legal guardianship of the above named child, a minor, do hereby authorize NWHSU chiropractic provider(s) to evaluate and treat as deemed advisable by a licensed chiropractic doctor.

_____ _____

(PARENT | GUARDIAN SIGNATURE) **(DATE)**

CLINICIAN ONLY

_____**, D.C.**

_____

(D.C. SIGNATURE) **(DATE)**

NORTHWESTERN HEALTH SCIENCES UNIVERSITY
Human Performance Center

INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL CONSULTING

I hereby give my consent for nutritional consulting which will provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle.

By receiving in-person nutritional consultation, due to the frequency of visits of other patients, the characteristics of the designated public health issue, and the nature of treatment, I have an elevated risk of contracting the virus simply by being in an office. Visits should be limited to the treatment of issues which necessitate an in-person visit based on my clinician's best judgment.

I understand that the provider is a Registered Dietitian or Nutritionist. Thus, will not diagnose medical conditions, but will provide nutritional support and nutritional education for conditions previously diagnosed by a licensed health care provider.

I understand that the methods of nutrition evaluation or nutrition testing made available to me are not intended to diagnose disease or a substitute for the diagnosis, treatment, or care of disease by a medical provider. Rather, these tests are intended to guide the development of an appropriate health-supportive program for me, compliment the chiropractic management plan and monitor my progress in achieving my health goal(s).

I understand that nutritional consultation can be an important support to my general health and disease management, these services are not a substitute for medical care.

I understand that the main risk factors involved in this form of nutritional consultation include food, supplement, and drug interactions. If at any time I begin to experience new or different symptoms, I will contact my provider and discontinue care until further instructed. Female patients who are pregnant, or could be pregnant, should advise their provider immediately as this may alter the nutritional recommendations.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my nutritionist or registered dietician 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'S NAME (Print)_____ **DATE OF BIRTH**_____

_____ _____ _____ _____

(PATIENT | GUARDIAN SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (DATE)

• CONSENT TO TREATMENT OF A MINOR •

I hereby request and authorize, _____, to perform diagnostic tests and provide
(Provider's Name)
nutritional counseling to my minor son or daughter: _____. As of this date, I have the
(Minor's Name)
legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. I my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____

(CLIENT | GUARDIAN SIGNATURE) (DATE)

• CLINICIAN ONLY •

_____ _____

(PROVIDER SIGNATURE) (DATE)

NORTHWESTERN HEALTH SCIENCES UNIVERSITY
Human Performance Center

AUTHORIZATION TO TREAT A MINOR & PRIVACY PLEDGE

Athlete's Name	Date

OUR PRIVACY PLEDGE: The NWHSU-Clinic System is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of the personal health information entrusted to us.

Ways in which the University may use or disclose your health care information include, but not limited to:

- Another health care provider within the University Care system, or to another provider or facility for the purpose of diagnosis, assessment or treatment of you r health.
- The School Nurse, Athletic Director, or head coach, when such information may be relevant to participation in school sport s activities.
- The use of that information within our practice for quality control or other operational purposes.
- Business associated that we contract with to perform a service for you and benefit and bill for it
- Research, when the University review board has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- The use of that information to contact you by telephone, mail, or email with appointment reminders, information about the clinic facilities, treatment alternatives or health -related information that you may be of interest to you.

Along with this consent form, you will have access to a detailed copy of our privacy policies in the clinic or can be found online at nwhealth.edu. We reserve the right to change our privacy practices as described in the notice. The most current notice, including the effective date, will be posted in the clinic facility and on the university website, nwhealth.edu.

Your Right to Limit Uses or Disclosers: You have the right to request that we do not disclose your child 's health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use disclosure of your child's health information, please let us know in writing.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOU PERSONAL HEALTH INFORM ATION . WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD-PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

[ ] I **acknowledge the NWHSU-notice of Privacy Practices**

Authorization

I hereby request and authorize the performance of diagnostic tests, procedures, and treatment to my child . This authorization also extends to all other personnel in this clinic and is intended to include radiographic examination at the clinician's discretion. I understand that information about my child's case may be used in case presentations (name and other personal information is kept confidential) .

As of this date, I have legal right to select and authorize health care services for the child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in anyway, I will immediately notify NWHSU.

Printed Parent/Guardians Name_____Relationship_____

Signature_____ Date_____

NORTHWESTERN HEALTH SCIENCES UNIVERSITY
Human Performance Center

ATHLETE DEMOGRAPHIC FORM

Patient Legal Name: _____
(Last Name, First Name , Middle Initial)

Preferred Name in Clinic: _____ Date of Birth: _____

Guardian Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Primary Healthcare Provider and/or Clinic: _____

ALLERGIES _____

_____

MEDICATIONS_____

_____

MAJOR ILLNESS/ INJURES/SURGERIES: _____

_____

SPORTS:

_____

_____

_____

_____

EMERGENCE CONTACT:

NAME _____

RELATIONSHIP: OPARENT O GUARDIAN O OTHER _____

PHONE :

WORK_____

HOME _____

CELL_____