

**MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT
STUDENT PHYSICAL EXAMINATION**

Student _____ D.O.B. _____ School _____

Parent's Name _____ Address _____

This physical examination is required to be performed by a physician (M.D., D.O.), advanced nurse practitioner (N.P.) or a physician's assistant (P.A.). NOTE: THIS FORM IS NOT TO BE USED FOR ATHLETIC PHYSICAL EXAMINATIONS.

PHYSICAL EXAMINATION

Examined: _____ Findings _____

(O = No abnormality √ = Abnormality -
specify under comments section)

Eyes _____

Ears _____

Nose/Throat _____

Mouth _____

Teeth _____

Lymph nodes _____

Heart _____

Lungs _____

Abdomen _____

Genitals _____

Orthopedic _____

Nervous system _____

Skin _____

Endocrine _____

Nutrition _____

Other _____

Height _____ Weight _____ B/P _____

Vision:

Both _____ Right _____ Left _____

Patch _____

Other: _____

Hearing: Right _____ Left _____

IMMUNIZATION RECORD

(Note: Please record month, day and year)

DTP/DTaP					
Td					
Polio					
MMR					
Measles					
Rubella					
Hib					
Hep B					
T.B. skin test					
Other:					

COMMENTS/FOLLOW-UP NEEDED: (continue on back of page if needed)

Date _____ Signature of Physician/N.P./P.A. _____

8. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?.....
 ___ Head ___ Shoulder ___ Thigh ___ Neck ___ Elbow ___ Knee ___ Yes ___ No
 ___ Forearm ___ Shin/Calf ___ Back ___ Wrist ___ Ankle ___ Hip ___ Chest

9. When was your last tetanus shot? _____
 When was your last measles immunization? _____
 10. When was your last menstrual period? _____

Explain "Yes" answers: _____

Medications regularly taken: _____

Health concerns/conditions: _____

I hereby state the above information is true and agree to guidelines as established by ASAA, Mat-Su School District, and Colony High School.

Dated this _____ day of _____, 20____.

Parent's signature: _____ Printed name: _____

Student's signature: _____ Printed name: _____

PHYSICAL
 To be performed & completed by a Physician, Advanced Nurse Practitioner or Physician's Assistant

ATHLETE'S NAME (print): _____ Yes No
 1. Have any members of your family under age 50 had a "heart attack" or sudden death? _____
 2. Have you ever passed out or had chest pain while or after exercising? _____
 3. Do you cough or have trouble breathing during or after exercise? _____
 4. Do you have any allergies? Explain: _____
 5. Have you ever had an illness/injury that required hospitalization, surgery or repeated doctor visits? Explain: _____

Age	Height	Weight	Blood Pressure	Vision: R/20	Vision: L/20	Correction:	Y	N
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INSTRUCTIONS: (O) if normal (X) if abnormal Please explain X by indicating # and using comments.

- | | | | |
|------------------------------|--------------------------------|------------------------|-------------------------------|
| 1. ___ Eyes/ears/nose/throat | 5. ___ Liver/spleen/abdomen | 9. ___ Head/neck | 13. ___ Ankles |
| 2. ___ PERRLA | 6. ___ Genitalia, Tanner stage | 10. ___ Shoulders/arms | 14. ___ Other musculoskeletal |
| 3. ___ Respiratory | 7. ___ Neurological | 11. ___ Knee/hip | 15. ___ Hearing acuity |
| 4. ___ Cardiovascular | 8. ___ Skin | 12. ___ Back | 16. ___ Lab-UA, HGB/HCT |

Comments: _____

I certify that I have on this date examined this pupil and find this pupil physically able to compete in all supervised activities not circled:
 BASEBALL BASKETBALL CHEERLEADING XC RUNNING XC SKIING FOOTBALL HOCKEY
 SOCCER SWIMMING/DIVING TENNIS TRACK VOLLEYBALL WRESTLING WEIGHT LIFTING SOFTBALL

Examining Physician's Signature: _____ Printed Name: _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE ACTIVITIES OFFICE.								
Physical Date	Practice Eligibility Date	S2 GPA 2000	Q1 GPA 2000	S1 GPA 2001	Q3 GPA 2001	Fee	Check	Cash



WASILLA MEDICAL CLINIC

1700 E. PARKS HWY. # 200

WASILLA, AK 99654

(907)-373-6055

AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR

I, the undersigned parent or guardian, of a minor: _____

(print name of minor)

pertinent allergies or other medical conditions _____

do hereby authorize Wasilla Medical Clinic, as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any licensed physician or surgeon whether the diagnosis or treatment is rendered at the office of the physician or at the hospital.

This authorization specifically includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a provider, in the exercise of his or her best judgment may deem advisable.

This authorization shall remain in effect from _____ to _____

unless revoked sooner in writing and delivered to said agent(s).

Date

Time

Signature of Parent or Guardian

Home Phone

Work Phone

Signature of Witness

Signature of Witness *If consent for treatment of minor is obtained by telephone, a second witness is required.

Wasilla Medical Clinic
1700 East Parks Hwy #200
Wasilla, AK 99654
(907) 373-6055 Fax (907) 373-6077

PATIENT INFORMATION

Patient Name: _____ SS. #: _____
 First name Initial Last name
Mailing Address: _____ City: _____
State: _____ Zip: _____ Patient's Employer: _____
Phone #'s: Home: _____ Work: _____ Emergency: _____ Cell: _____
Date of Birth: _____ Sex: Male Female
Marital Status _____ Spouses Name: _____ Date of Birth: _____
Spouses Social Sec. # _____ Spouses Employer: _____

GUARANTOR/BILLING INFORMATION:

Person responsible for patient: _____ SEX: M F
 First name Initial Last name
Address: _____ City: _____ State: _____
Phone: _____ Social Security #: _____ Date of Birth: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____
Cardholder Name: _____ Relationship to patient: _____
Social Security #: _____ Date of Birth: _____ Sex: M F
I.D. #: _____ Group #: _____
Secondary Insurance Company: _____
Cardholder Name: _____ Relationship to Patient: _____
Social Security #: _____ Date of Birth: _____ Sex: M F
I.D. #: _____ Group #: _____

**HIPPA PRIVACY RULE
CONSENT, INFORMATION DISCLOSURE, AND INSURANCE AUTHORIZATION**

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used as follows only with patient consent. I hereby authorize Dimond Medical Clinic, LLC, dba Wasilla Medical Clinic, to furnish information to other providers, healthcare or treatment facilities, and my insurance companies for purposes of treatment, payment, and healthcare operations. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE

Patient/Guardian Signature Date Witness Date

NOTICE OF PRIVACY PRACTICES

WASILLA MEDICAL CLINIC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of Apr 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Alaska School Activities Association
HEALTH EXAMINATION FORM

MEDICAL HISTORY TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

<i>Last Name (Print)</i>	<i>First Name (Print)</i>	<i>Initial</i>	<i>Date of Birth</i>

Have you or any members of your family under age 50 had a "heart attack" or sudden death? Y ___ N ___
 Have you ever had any chest pain or passed out while exercising? Y ___ N ___
 Do you cough or have trouble breathing during or after exercise? Y ___ N ___
 Have you ever had an illness or injury that required hospitalization? Y ___ N ___
 Have you ever made repeated visits to a doctor for an illness or injury? Y ___ N ___
 Do you have any allergies? Y ___ N ___
 Are you presently taking any medications? Y ___ N ___
 In the past year, have you had a significant illness or injury? Y ___ N ___

Explain any yes answers: _____

I hereby consent to the information on the reverse side of this form

Student Signature

Parent Signature

Date

HEALTH EXAMINATION TO BE COMPLETED BY PHYSICIAN

<i>AGE</i>	<i>HEIGHT</i>	<i>WEIGHT</i>	<i>BLOOD PRESSURE</i>	<i>VISION R/20</i>	<i>VISION L/20</i>

Circle any of the following that are abnormal and explain Under comments:

Eyes/Ears/Nose/Throat Genitalia, Tanner Stage ___ Knee/Hip PERRLA Neurological
 Back Respiratory Skin Ankles Cardiovascular Head/Neck Other Musculoskeletal
 Liver/Spleen/Abdomen LAB: UA, HGB/HCT (as needed) DT (Date): _____

Comments: _____

I certify that on this date, I have examined this student and find him/her physically able to compete in all supervised activities not crossed out: Wrestling, Football, Gymnastics, Swimming, Diving, Soccer, Cheerleading, Riflery, Weight Training, Ice Hockey, Track and Field, Volley Ball, Basketball, Tennis, Cross Country Skiing, Cross Country Running, Baseball, Softball

PHYSICIAN'S NAME (PRINTED)

Examining Physician's Signature

Date of Examination

 Physician's Address

--	--

City

State

--	--

Phone Number

Zip Code

The physician's stamp is required in this space

Waiilla Medical Clinic
 1700 E. Parks Hwy #200
 Waiilla, AK 99654
 (907)373-6055

White: School

Yellow: Student/Parent

Pink: Examining Physician

WASILLA MEDICAL CLINIC

1700 E PARKS HIGHWAY
SUITE 200
WASILLA, AK 99654

Phone 907-373-6055
Fax 907-373-6077

WMC BILLING OVERVIEW

Effective January 2, 2003 the following billing policies will be implemented:

If you have no insurance or insurance that will not cover your visit, payment is expected at the time services are rendered. Payment plans are not normal office policy. A charge of \$25.00 will be added to all returned checks.

Alaska Medicaid recipients are required to present proof of coverage once each month and a \$3.00 co-pay at each visit if 18 or older.

We will accept assignment of benefits for most insurance companies if:

- 1) You provide our office with all the billing information for your particular insurance coverage,
- 2) You agree to pay your co-payment at the time services are rendered,
- 3) You have met your deductible and are being seen for a covered service,
- 4) You have a good credit record with our office and have not previously misstated insurance coverage, deductibles, or co-pays,
- 5) You agree to pay the balance of all charges and fees within 30 days after the insurance company has paid or 90 days after services are rendered whether or not your insurance has paid on your account. Failure to pay off your account within 90 days from the date of service could result in your receiving a bad credit record with our office. Failure to pay your account within 120 days from date of service will result in your account being turned over for collections as provided by the laws of this state. Your credit rating will be affected.

Insurance is a contract between you and your insurance company. We are NOT a party to this in most cases (we will inform you if we are a party to your insurance contact and will handle claims according to our agreement with the insurance company, if one exists). Our agreement to file your claim is a courtesy and you are ultimately responsible for all charges.

I have read and understand the above information. I agree that Wasilla Medical Clinic may submit my account to collections if I allow my account to extend beyond 120 days after the date of service.

Responsible Party Signature

Date

Witness, Wasilla Medical Clinic

Date

DS/plb
12/30/02

PATIENT CONSENT FORM

**WASILLA MEDICAL CLINIC
1700 E PARKS HWY #200
WASILLA, AK 99654**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Wasilla Medical Clinic

1700 E. PARKS HWY #200
WASILLA, AK 99654

(907) 373-6055
FAX (907) 373-6077

**AUTHORIZATION TO DISCLOSE
MEDICAL INFORMATION**

DATE: _____

Patient Name: _____ Other Name: _____

I am the : _____ Patient _____ Parent _____ Guardian _____ Designee

DATE OF BIRTH: _____ SS# _____

I hereby authorize my medical records for dates of treatment _____ or records from _____ to _____ to be released from:

Wasilla Medical Clinic _____ To: _____
or

Other (specify): _____ To: Wasilla Medical Clinic

Documents Requested or Released:

- _____ 1. Chart Notes
- _____ 2. Lab reports
- _____ 3. History & Physical
- _____ 4. Radiology Reports
- _____ 5. ER reports
- _____ 6. Other (specify)

For the purpose of :

- _____ 1. Further Treatment
- _____ 2. Insurance claims
- _____ 3. Workers compensation
- _____ 4. Legal request
- _____ 5. Other (please list)

**HIPPA PRIVACY RULE
CONSENT, INFORMATION DISCLOSURE, AND AUTHORIZATION**

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used only with patient consent. I hereby authorize Dimond Medical Clinic, LLC, dba Wasilla Medical Clinic to furnish information to other providers, healthcare or treatment facilities.

I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal Law. My initials and signature below authorize release of the following type of information:

_____ Drug/Alcohol abuse _____ Mental Health _____ HIV/AIDS

This consent will expire on _____ or in 90 days from date stated above, whichever comes first.

Patient Signature

Parent, Guardian, Designee