Please print this form, complete and sign, and email to athletics@dxtesting.com or fax to (855) 400-8262. Please also include a copy of your insurance card, front and back.

STUDENT/ATHLETE Information (*Enter N/A for fields that do not apply*)

First Name: _____ Last Name:_____

Gender: _____

Date of Birth (mm/dd/yyyy): _____ ***Testing offered to individuals ages 12-25***

Phone #: _____ Email Address: _____

Height: _____ Weight: _____

School/University Name:_____

POLICYHOLDER Information (*Enter N/A for fields that do not apply*)

First Name: _____ Last Name:_____

Gender: _____

Date of Birth (mm/dd/yyyy): _____

Home Phone #: _____ Cell Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Email Address to Deliver Student Athlete's Test Results: _____

POLICYHOLDER Primary Insurance (*Enter N/A for fields that do not apply*)

Insurance Company: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____

Policy/Claim #: _____ Group #: _____

Relationship of Insured to Patient: _____

☐ I have a Health Savings Account (HSA), Flexible Spending Account (FSA), or Health Reimbursement Account (HRA)

7000 West Palmetto Park Road | Suite 205 | Boca Raton, Florida 33433
P: (855) 200-8262 | F: (855) 400-8262 | www.wimbledonhealthpartners.com

STUDENT/ATHLETE Personal Questionnaire

Patient Name: _____ _____

	Check One YES	NO
Have you ever experienced chest pain during exercise?	☐	☐
Have you had a deterioration in your ability to exercise? Explain below.	☐	☐
_____		
Have you ever had swelling? If so, where? _____	☐	☐
Do you experience a rapid, fluttering, or pounding heart?.....	☐	☐
Do you experience shortness of breath or difficulties breathing during physical activity?	☐	☐
Are you diabetic?	☐	☐
Do you experience lightheadedness during exercise?	☐	☐
Have you experienced any unexplained weight gain changes?	☐	☐
Have you ever experienced loss of consciousness during exercise?	☐	☐
Do you have loud snoring (sleep apnea)?	☐	☐
Have you ever been restricted from sports due to heart problems?	☐	☐
Have you ever been diagnosed with a heart murmur?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you ever had elevated cholesterol levels?	☐	☐
Have you ever had a heart infection?	☐	☐
Has a health provider ever ordered a heart test? (EKG, echo, stress test, Holter monitor)	☐	☐
Do you experience unexplained difficulty breathing or fatigue during exercise?	☐	☐
Any family member (blood relative):		
Under the age of 50 with a heart condition?.....	☐	☐
Diagnosed with Marfan syndrome?	☐	☐
Died of a heart problem before the age of 50?	☐	☐
Died from no known reason?	☐	☐
Died while exercising?	☐	☐

Do you have: ☐ Asthma ☐ Cough ☐ Fever ☐ Abdominal Pain ☐ Known Heart Problems Explain

"YES" answers here (include relevant dates):

_____

_____

_____ _____

Signature of patient or parent/legal guardian if patient is a minor Date

7000 West Palmetto Park Road | Suite 205 | Boca Raton, Florida 33433
P: (855) 200-8262 | F: (855) 400-8262 | www.wimbledonhealthpartners.com

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

1) I give permission for myself, or my dependent, to receive diagnostic testing services provided by Wimbledon Health Partners and their affiliates.
   a. Electrocardiogram (EKG)
   b. Echocardiogram
   c. Vascular Ultrasound

2) I understand that the diagnostic testing results will be read and interpreted by a licensed and board certified cardiologist, pediatric cardiologist, or radiologist designated by Wimbledon Health Partners, and I hereby consent to the same.

   I understand that I can request and receive a copy of the report of the cardiologist's, pediatric cardiologist's, or radiologist's findings, and any recommendations based on those findings by providing a signed release for medical information.

3) I authorize the release of any medical information necessary to process insurance claims, including a copy of my insurance policy or any other document that specifies or describes my health benefits, to my physician or his or her medical corporation, and/or Wimbledon Health Partners, LLC and/or any of its related medical companies.

   I also authorize payment directly to Wimbledon Health Partners, LLC and/or any of its related medical companies, of all benefits otherwise payable to me. I further authorize Wimbledon Health Partners, LLC and/or any of its related medical companies to act as my representative in all matters pertaining to my insurance benefits and to pursue the collection of all claims and to take any legal action necessary to obtain payment. I assign any and all legal rights which I am entitled to by my policy or governing authorities to Wimbledon Health Partners, LLC.

   I understand that I am financially responsible for all out-of-pocket charges such as copays, coinsurance and deductibles. Should I receive a payment directly from my insurance company, I will forward it immediately to: Wimbledon Health Partners, LLC, 7000 West Palmetto Park Road, Suite 205, Boca Raton, FL 33433.

_____

Patient's Full Name

_____ _____

Signature of patient or parent/legal guardian if patient is a minor Date

_____

Parent or legal guardian name, if applicable (please print)

Wimbledon Health Partners, LLC and Related Entities

7000 West Palmetto Park Road, Suite 205 | Boca Raton, Florida 33433
(855) 200-8262 | Contact: HIPAA Privacy Officer

HIPAA Notice of Privacy Practices

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.

"Protected health information" or "PHI", is information about, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PHI

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services, including with a third party. For example, your PHI may be provided to the person(s), or class of persons you have designated to receive it or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining payment of our claim to your insurance company may require that your relevant health information be disclosed to the health plan to obtain payment.

Healthcare Operations: We may use or disclose your PHI to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical professionals, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical professionals who assist us in patient care. We may also call you by name in the waiting area when a technician is ready to see you.

Required by Law: We may use or disclose your PHI without your authorization as required by law. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, but that will not affect any action taken in reliance on the authorization.

YOUR RIGHTS

You have the right to inspect and copy your PHI except the following per federal law: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care, stating the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right upon request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request.

You may have the right to have your PHI amended. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We are required to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us if you believe your privacy rights have been violated by using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Privacy Officer in person or by phone at our phone number listed on this document.

I acknowledge receipt of this notice:

Patient Name: _____

Date: _____

_____
Signature of patient or parent/legal guardian if patient is a minor