



## **Back To Athletics - Liberty Hospital Sports Medicine**

### **Consent to Treatment:**

I recognize that I am, or my minor child is, suffering from a condition requiring athletic training rehabilitation services and treatment. I understand that such rehabilitation and related services may involve bodily contact, touching, and/or contact of a sensitive nature. I acknowledge that no guarantees have been made to me about the outcome of treatment. I hereby consent to the rendering of services explained to me by Liberty Hospital Sports Medicine Athletic Trainers.

### **Waiver and Release:**

I agree to release, indemnify, and hold harmless New Liberty Hospital District(\*NLHD\*) (a political subdivision) and its affiliates, trustees, employees, volunteers, and agents associated with the Liberty Hospital Sports Medicine facility from any and all claims, liability, loss of service and cause of action of any kind, including personal injury and property damage, arising from participation in this program, whether caused by NLHD, its affiliates, trustees, employees, volunteers, and agents or other participants of the program. I authorize the supervisors of this program to act according to their best judgment in an emergency and I will accept financial responsibility for such treatment.

### **Release of Information:**

Liberty Hospital Sports Medicine recognizes the importance of communication in the treatment process. We believe coaches, team medical personal such as athletic trainers and school officials such as school nurses and athletic directors play a vital role in keeping athletes safe.

I authorize the release of any or all medical information pertaining to me, or my minor child's, condition and progress to be released to my athletic team or organization as deemed necessary.

### **Financial Policy:**

"Back to Athletics-Injury Screens" is a fee for service program. I understand that payment for services is due at the time of service. Liberty Hospital Sports Medicine accepts cash, check, Visa, Discover, and Master Card.

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 Participant Signature

Date

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 Parent or Guardian /DPOA Signature

Date