Oregon Medical Group, PC
Notice of Patient Responsibility

Sports Physical Examination

Patient Label

Patient Name: ________________________________ Age: ____________________

Insurance Plan: ________________________________ Date of Service: ____________

Please review below the descriptions of the two services we offer for physicals at this office and indicate the service you are requesting by checking the box at the left:

☐ **Health maintenance visit**–

- A head to toe physical is performed
- The physician will discuss nutrition, exercise, safety, and any concerns (such as acne or asthma)
- The physician will recommend tests and vaccines based on age and health status
- This visit will be billed to the insurance or patient according to the insurance agreement
- If a sports clearance form is needed, it will be filled out based upon examination up to 2 years following the last exam.*
- We recommend children have a health maintenance visit every 1-2 years after age 5 according to the American Academy of Pediatrics. Dependant on your insurance benefits a health maintenance visit may only be covered every two years. Please be sure to check with your insurance regarding your coverage for these exams.

☐ **Sports Physical Only –**

- A limited physical is performed, examining only areas needed to determine the patient's ability to participate safely in sports activities.
- Discussion and advice will be limited to issues impacting sports participation.
- The cost covers the exam fee only and payment should be collected at the time of service.
- Any vaccines or testing needed will be billed to insurance or the patient.
- If additional issues are identified and/or addressed at the visit, a separate fee may be billed to the insurance or patient according to the insurance agreement.
- A sports clearance form will be filled out upon request.*
- In general, most insurance plans do not cover a sports physical exam.

*Because clearance to participate in sports is made based on medical criteria, should a health problem be found during the visit, the sports clearance form will not be signed until the health problem is fully investigated and the physician is sure the athlete can participate safely. Please plan the timing of your child's physical with this in mind.

Service to be performed: ____

Approximate Cost: $________________________ Condition/Diagnosis: ______________________

I understand my health plan may not cover the service marked above. I have asked Oregon Medical Group to perform the above service and I agree to be personally and fully responsible for payment if the services are not paid by my insurance. *I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. To ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.*

____________________ ______________________________________
Date Signature of Patient/Guardian