NEUROSPORTZ

"Engineering Elite Athletes"

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www.neurosportz.com

Getting To Know You Form

Welcome to Neurosportz Applied Neuroscience. You're here because you want to be the best athlete you can be, and we can help you reach that pinnacle. We require this information to provide you with quality care and training. Our clinic follows the guidelines of best practice for the management of health information in private practice. This means your personal health information is kept private and secure.

Your Details

First Name	Last Name	Date of Birth / /
School /Team/Club	Age	(Circle) Gender: M / F
Primary Sport	Secondary Sport	Primary Position

Description of challenge(s) you have in your sport____

____

____

Referred or Recommended By

Trainer/Coach/Agent/Doctor:

Email/Phone Number of that Individual:

This is so we can contact them to thank them for their referral

Your Contact Details

Email Address

Address	City/State	Zip Code
Phone (Mobile)	Phone (Home)	Ph.(W)

Parent/Guardian Name(s) (if under age 18)

Opportunities for Improvement

○ Vision	○ Hand-Eye Coordination	○ Concentration/Focus/Attention	○ Confidence

Other:

Emergency Contact Details

Name	Relationship To You	
Ph.(Mobile)	Ph.(Home)	Ph.(W)

Demographic Info

Height:	Weight:	Body Mass Index	Ethnicity

Contact Lenses/Glasses/Laser Vision Correction:

Allergies **(mark the box and circle relevant)**

☐ No Known Drug Allergies	☐ Latex | Bee Stings | Peanuts
☐ Aspirin | Penicillin | Sulfa	**Others**

Do you use an EpiPen? Do you carry and EpiPen?

Getting to Know You Form – Page 2

Your Health History

Please list any medications you use, including prescription, over the counter medications, vitamins and herbs:

Name	Mg/day	Reason Prescribed or Taking

Have you had any specialist consultations in the last 12 months? If yes, please specify.

Have you even suffered a **Concussion**? If so, how many and when? Who treats you for this condition?

Do you have any Medical Conditions or a History of Surgery/Operations/Previous Injuries?

Do any diseases or health conditions run in your family? If yes, please specify below.

Smoking History	Alcohol
☐ Never	☐Non Drinker
☐ Former Smoker, when did you quit?	☐Rarely/Light
☐ Current Smoker	☐Moderate
☐ Packs/day	☐Heavy

List types of alcohol drunk

Getting to Know You Form – Page 3

Please list any other recreational drug use. For example-- marijuana, adderall, ritalin, cocaine, speed, ice, ecstasy, etc. (this information will remain confidential)

Name of Drug	Date Last Used

Please indicate whether you have experienced any of the following conditions		
☐ Acne (under treatment)	☐ Cancer/Malignancy	☐ Hepatitis
☐ ADHD/ADD	☐ Cerebral Palsy	☐ Heart Disease
☐ Alcoholism	☐ Chicken Pox	☐ High Cholesterol
☐ Anxiety	☐ Kidney Disease	☐ HIV/AIDS-to remain confidential
☐ Anemia	☐ Chronic Bronchitis	
☐ Arthritis	☐ Depression	☐ High Blood Pressure
☐ Asthma	☐ Diabetes Mellitus	☐ Insomnia/Sleep Issues
☐ Autism Spectrum	☐ Digestive Trouble	☐ Migraines
☐ Bipolar Disorder	☐ Ear/Hearing Problems	☐ Seizures/Epilepsy
☐ Blood Disorder	☐ Eating Disorder	☐ Thyroid Issues
☐ Breast Disease	☐ Emotional/Mental Issues	☐ Tuberculosis
If yes to any of the above, please explain:		
Do you have any other diseases or conditions that you are aware of? Yes ☐	No ☐	
If yes, please explain:		

Health Support Team		
Primary Care Doctor's Name		
Doctor's Phone Number		
Doctor's Fax Number		
Other Health Care Professionals Currently Consulting (counselor, specialist, chiropractor, psychologist, etc.)		
Name	Field	Contact Information
Feedback		

Getting to Know You Form – Page 4		
How did you find out about Neurosportz Applied Neuroscience (put an "x" to all that apply)		
☐ Word of Mouth	☐ White Pages	☐ Press/News Program
☐ Relatives	☐ Signage	☐ Yellow Pages
☐ Workshops	☐ Leaflets/flyer	☐ Pharmacy
☐ School newsletter	☐ Notice board	☐ Google
☐ Website	☐ Facebook	☐ Instagram
☐ Search Engine	☐ YouTube	☐ Email
☐Other (please specify)		

Would you like to receive our newsletter by email? ☐ Yes ☐ No

Privacy, Consent, Waiver, Release, and Assumption of Risk

To provide a high standard of health care we need to collect personal information from our patients. This information is usually collected from the patient, but can also be collected from family members and other health care providers. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your clinician.

Health Insurance Portability and Accountability Act (HIPPA)
Acknowledgement of Receipt of "Notice of Privacy Practices"

I consent to the use or disclosure of my protected health information by Neurosportz Applied Neuroscience, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations. My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a responsible basis to believe the information may identify me.

Consent To Share Information

I hereby grant permission for Neurosportz Applied Neuroscience, PLLC, its doctor's and staff , and my trainer/coach/agent/doctor to exchange information concerning my performance on the field of play and in the vision/neuro-cognitive training clinic. I hereby give permission to have this information e-mailed, faxed, and/or mailed when necessary and appropriate. I consent to the use of my name and photo on the Wall of Fame or in other publications/websites (signature of the Waiver below implies consent to share information).

WAIVER, RELEASE AND ASSUMPTION OF RISK

PARTICIPATION IN VISION THERAPY/NEURO-COGNITIVE BRAIN TRAINING IS CONSIRED SAFE BUT ENTAILS KNOWN AND UNANTICIPATED RISKS THAT COULD RESULT IN PHYSICAL AND/OR EMOTIONAL INJURY, PARALYSIS, DEATH OR DAMAGE TO YOUR SELF AND/OR TO OTHERS. RISKS MAY INCLUDE, BUT ARE NOT LIMITED TO, SLIPPING AND FALLING, COLLISIONS WITH FIXED OBJECTS AND/OR OTHER PEOPLE WHICH MAY RESULT IN SPRAINS, FRACTURES, BREAKS, SCRAPES, BRUISES, DISLOCATIONS AND INJURIES TO HEAD, BACK AND NECK.

In consideration of the services provided by RELIEF JONES III MD, PLLC, a Texas professional limited liability company, who is the owner and operator of NEUROSPORTZ APPLIED NEUROSCIENCE, PLLC ("Neurosportz") and my desire to participate and/or spectate in the activities and services provided by Relief Jones III MD, PLLC at Neurosportz (Relief Jones III MD, PLLC and its individual members, managers, directors, officers, agents, employees, volunteers, representatives, servants, predecessors, successors, assigns, affiliated entities, heirs, personal representatives and all other persons, firms, or entities claiming by or through them are hereinafter known as "Neurosportz"): I, (name as printed below), on behalf of myself, my spouse, my child(ren), minor

child for whom I am appointed guardian, my parent(s), my heirs, assigns, personal representative and estate hereby:

(a) agree to use Neurosportz and its facilities in a safe and responsible manner;

(b) agree to abide by Neurosportz rules and instructions and the directions of Neurosportz employees and representatives, whereby I acknowledge that

(i) those rules, instructions and directions arc intended to promote the safety of both myself and others;
(ii) my failure or refusal to abide by those rules, instructions and directions can lead to the immediate revocation of my right to use Neurosportz and its facilities, without any right to refund of any payments made; and
(iii) in the event of sickness, accident or injury, I authorize Neurosportz employees and representatives to obtain, on my behalf, emergency medical treatment and to secure such medical treatment at my expense;

(c) agree to fully and forever waive, release and discharge Relief Jones III MD PLLC d/b/a Neurosportz Applied Neuroscience, PLLC from any and all claims, actions, causes of action, demands, judgments, damages (including compensatory, general, special, consequential, exemplary and punitive), liability or obligations of any nature or kind, whether known at the time I leave Neurosportz or which may arise or become known later, which accrue on account of, or in any way arise out of or in connection with:

(a) my activities within Neurosportz;
(b) the activities within Neurosportz by others;
(c) the operation of Neurosportz;
(d) my use of any and all of Neurosportz facilities; and
(e) my use of any and all equipment at Neurosportz, whether owned by me, Neurosportz or a third party;

(d) agree to indemnify and hold Relief Jones III MD PLLC d/b/a Neurosportz Applied Neuroscience, PLLC harmless from and against any and all losses, liabilities, claims, obligations, costs, damages, and/or expenses whatsoever, including, but not limited to, any and all attorneys' fees, costs, damages and/or judgments directly or indirectly arising out of, or relating to my acts or omissions while participating in any activities at Neurosportz;

(e) agree to accept and assume all of the risks which accompany Neurosportz's activities and represent that my participation in the activities is purely voluntary and I elect to participate in the activities notwithstanding the risks;

(f) fully understand that participating in the activities within Neurosportz involves physical and mental exertion; and accordingly represent that I

(i) am in sufficient good health to participate in activities at Neurosportz;
(ii) I do not have any pre-existing physical or medical condition, including without limitation pregnancy, orthopedic problems, including back problems; heart problems; and/or breathing problems, that might be impacted or worsened by my use of Neurosportz; and
(iii) will not use Neurosportz and its facilities while under the use of any drugs, alcohol or medications that may impair my physical abilities or judgment; and,

(g) certify that 1 have adequate insurance to cover any injury or damage I may cause or suffer while participating in the activities within Neurosportz, or if not, I agree to bear the costs of such injury or damage to myself and others. I agree that any legal proceeding shall be filed solely in the state of Texas and I further agree that the substantive law of Texas shall apply in that action without regard to the conflict of law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect. By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against Neurosportz on the

basis of any claim from which I have released them herein. I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms. I understand and agree that:

(i) that this Waiver, Release and Assumption of Risk gives up important legal rights;
(ii) I am giving up these important legal rights voluntarily, freely, under no threat of duress, without inducement, promise or guarantee being communicated to me; and
(iii) the signature below is proof of my intention to execute a complete and unconditional WAIVER AND RELEASE of all liability to the full extent of the law.

Date ………………………………………………………..

PARTICIPANT: (Signature) ………………………………………………………..

Print Name (Picture ID Required) ………………………………………………………..

If the Participant is not 18 years of age or older, then the following Parent or Guardian Consent must be read and signed before the Participant is allowed to use Neurosportz and its facilities.

PARENT OR GUARDIAN CONSENT

I have read and understand the terms of this WAIVER, RELEASE AND ASSUMPTION OF RISK AGREEMENT and unconditionally agree to its full terms, statements, warranties, notices, representations, waivers and releases on behalf of both myself and marital community, if any, and my child or ward, whose name is:

Print Your Child's or Ward's Name ………………………………………………………..

All such terms, statements, warranties, notices, representations, waivers and releases fully apply to my child or ward as if I was the participant. I understand that, by signing this Consent, I am giving up important legal rights both on behalf of myself and my child or ward regarding potential rights and claims against Neurosportz. I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Date ………………………………………………………..

PARENT/GUARDIAN: (Signature) ………………………………………………………..

Print Name (Picture I.D. Required) ………………………………………………………..

Relationship to Child or Ward ………………………………………………………..

Parent/Guardian Telephone Number ………………………………………………………..

Parent/Guardian Address ………………………………………………………..

………………………………………………………..