



# M.O.S.T.

## Metro Orthopedics & Sports Therapy

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### CONSENT FOR ImPACT TESTING and RELEASE OF INFORMATION

I give my permission for (name of child/self) \_\_\_\_\_

(Child/self's date of birth) \_\_\_\_\_

To have a pre-injury/baseline and, if needed, a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) test administered at Metro Orthopedics and Sports Therapy (MOST). I understand that my child/self may need to be tested more than once, depending upon the results of the test, as compared to my child/self's baseline test or the population normal (if no baseline is necessary)

I agree to pay a fee of \$35.00 for the initial baseline/consultation test and \$45.00 for the first post-concussion/evaluation test. Additional post-concussion tests, when needed, would be charged a fee of \$10.00 each

MOST will share/release the ImPACT results to my child/self's primary care physician, neurologist, or other treating physician, to James Gilbert, MD, one of Metro Orthopedics and Sports Therapy physicians, and to our Certified Athletic Trainers

I understand that general information about the test data may be provided to my child's (students) guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian/self: \_\_\_\_\_

Signature of parent or guardian/self: \_\_\_\_\_

Date: \_\_\_\_\_

#### PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Pediatrician/Family doctor: \_\_\_\_\_

Primary Physician Medical Practice name: \_\_\_\_\_

Phone number of primary doctor: \_\_\_\_\_

Patient's home address: \_\_\_\_\_

Parent or guardian/self phone numbers (please indicate preferred contact number & time if necessary):

\_\_\_\_\_ (H) \_\_\_\_\_ (W)

\_\_\_\_\_ (cell)

**PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR APPOINTMENT**