Southdale pediatric associates, ltd.

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AFTER HOURS-EMERGENCIES 952-653-0261

Consent Form

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

At the time of testing, I understand that there will be an out of pocket fee for the pre-concussion test which is not covered by insurance. Any post-concussion testing will be billed to your insurance.

Printed Name of Patient _____

Sport _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent Date