Children's Hospital
of The King's Daughters
Sports Medicine
Training and Treatment for Young Athletes
(757)668-PLAY
www.chkd.org/sportsmed

July 1, 2026

Dear Parents,

As part of our commitment to serve the sports community, Children's Hospital of the King's Daughters (CHKD) Sports Medicine Program has joined with Governor's School for the Arts (GSA) to provide on-site medical screenings. Dr. Joel Brenner, a sports medicine physician with expertise in assessment and treatment of dancers and other performing artists, and Emily Hafer, a physical therapist (PT) and Board Certified Sports Clinical Specialist, will come to the dance studio most Wednesdays to assess any musculoskeletal injuries or painful conditions that the students are reporting. After screening from either Dr. Brenner or Emily, a recommendation may be made for either a follow-up physician visit (you can choose to follow up with either Dr. Brenner by calling 668-PLAY (7529) or with your child's own physician) or your child may be given some physical therapy exercises to do on their own in an attempt to mitigate further problems. CHKD provides this service in the studio free of charge. Often when minor injuries and pains can be assessed early, interventions can be given to decrease pain and prevent further injury.

You may choose whether or not to allow your child to be screened by our medical team. If you agree, please complete the attached forms and return to GSA Department. The forms are as follows:

1. Treatment and Payment acknowledgment: This MUST be signed to allow your child to participate in the screening. Please initial each box and sign at the bottom **(no payment will be collected at any time)**
2. Email consent form: Allows the staff at CHKD to reach out to you regarding any concerns
3. Authorization to disclose information: Allows the staff at CHKD to share the results of any screens with the staff at GSA
4. Sports Performance Academy Waiver: Provides CHKD staff with emergency contacts, as well as any pertinent history

If you have any questions about this program, feel free to contact Emily Hafer, PT, DPT, SCS, CHKD's Dance Program Coordinator at 757-668-2394.

Thank you,

CHKD's Sports Medicine Team

0 0 7 5 9

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Children's Hospital of The King's Daughters Health System

TREATMENT AND PAYMENTACKNOWLEDGMENT/CONSENT

CONSENT FOR TREATMENT

I hereby request and consent to medical and/or diagnostic treatment, including admission if deemed necessary, by Children's Hospital of The King's Daughters, Incorporated ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG"), and hereby authorize such entities and their physicians (and whomever he/she may designate as his/her assistant(s), including Residents and any CHKD professional staff physician) and employees to treat myself or minor(s) in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, and medical or surgical procedures. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. Virginia law authorizes health care providers to test patients for HIV and Hepatitis B & C antibodies when a health care provider or any person employed by or under the direction and control of a health care provider is exposed to the body fluids of a patient in a manner that may transmit HIV or the Hepatitis A or B viruses. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to my physician or healthcare provider. I further consent to the taking of photographs/videos for treatment, security, public health, healthcare operations, and/or payment purposes. Date:_____ Initials:_____

OBLIGATION OF PAYMENT

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered. **I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to CHKDHS and/or CSG for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory and/or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand that I will receive a separate statement and bill from the laboratory and/or radiology department performing the test.** If all charges are not paid when due to CHKDHS and/or CSG, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed thirty three & one-third% (33 1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral.

Date:_____ Initials:_____

BALANCES DUE AND BILLING QUESTIONS

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt ofmy statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of $25.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. All billing inquiries can be directed to the CHKDHS and/or CSG Billing Representative where care was received. Date:_____ Initials:_____

COMMUNICATION PREFERENCE

- If email address(es) is/are provided, I consent to CHKDHS' and/or CSG 's use of encrypted email to send me communications that may include protected health information.
- If mobile phone numbers is/are provided, I consent to CHKDHS and/or CSG 's use of unsecured SMS text messaging to send me communications that may include protected health information.

By signing this consent form, I acknowledge that I have the authority to provide consent and am granting permission to CHKDHS and/or CSG or their affiliates, clinical providers, business associates, billing services, collection agencies, agents, or third parties who may act on their behalf to contact me for any reason or purpose, including those related to my account, insurance, billing, payment, and/or the care rendered on the mobile phone number(s) provided on this or other form(s) or updated at a later time. I understand that I may choose to grant permission to contact me via phone call and text message, or phone call only (no texts). Consent is not required; I may opt-out of communications sent to my cell phone number(s). I retain the right to revoke permission at any time. I understand that communications may be made as a direct dial call or through the use of SMS text messages, live, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system," computer-aided technologies, or "autodialer". Depending on my mobile service plan, message and data rates may be assessed by my mobile provider. I may withdraw consent or opt-out at any time by providing written notice to Physician Practice Management, by emailing Text.Opt@chkd.org, by calling CHKD at (757) 668-8577, or by visiting the website www.chkd.org/Text0pt. Responding to SMS text messages with "STOP" will also withdraw my consent. I understand that the person signing is not required to sign the agreement as a condition of securing or receiving any services with CHKDHS and/or CSG.

Date:_____ Initials:_____

ACKNOWLEDGMENTS/Certifications

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:

- I received a medical screening and stabilization treatment prior to being asked about financial information while seeking care for a deemed medical emergency.
- I was offered (a) the "Patient/Family Rights & Responsibilities" form and provided (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" form on the date of this Agreement and was given an opportunity to ask questions about the information provided.
- I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the payment terms contained in this form.

I certify that this form has been fully explained to me, that I have had any necessary communication assistance, I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws. I acknowledge that any form completed by CHKDHS and/or CSG shall not be changed or altered by a parent/guardian/patient and understand that if it is changed or altered, it may jeopardize my child's health or safety based on provider(s)'s recommendation(s). Date:_____ Initials:_____

Advance Directive to be completed if patient is an adult (18 years or older): Does the patient have an advance directive? Yes__ No__

PATIENT(S)NAME(pleaseprint):_____ **DATE OF BIRTH:**_____

SIGNATURE OF PATIENT/LEGAL GUARDIAN	RELATIONSHIP TO PATIENT/LEGAL AUTHORITY	DATE	TIME

Witness:_____ Date:_____ Time:_____

For office use only:

2nd Witness: (Verbal Consent Only)	Date	Name of Person Accompanying Patient

0 0 7 6 4

Children's Hospital of The King's Daughters Health System
601 Children's Lane, Norfolk, VA 23507-1910

FOR CHKD OFFICE USE ONLY:
Medical Record #:

Authorization To Use Or Disclose Protected Health Information-SMPT Community Outreach Services

PARTICIPANT NAME: (PLEASE PRINT)	DATE OF BIRTH:

I AUTHORIZE: Children's Hospital of the King's Daughters Health System (CHKDHS)
601 Children's Lane, Norfolk, VA 23507-1910

TO DISCLOSE: Information about services provided by Sports Medicine Physical Therapy staff and/or the condition of the participant identified above as related to sports activities.

TO: _____

FOR THE FOLLOWING PURPOSE: At the request of the individual

NOTE: The purpose is not required if the disclosure is requested by the patient.

If the disclosure concerns substance use disorder under the Federal Substance Abuse Confidentiality Requirements, a separate authorization for disclosure of substance use disorder information is required.

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. **(NOTE: The recipient may be prohibited from re-disclosing substance use disorder information under the Federal Substance Abuse Confidentiality Requirements without my specific written consent.)**

I understand that I may revoke this authorization at any time except to the extent action has been taken in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Health Information Management, Children's Hospital of The King's Daughters, 601 Children's Lane, Norfolk, VA 23507-1910. (The written revocation must be legible and include the name and date of birth of the patient, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to the receive the information, the signature of the person with legal authority for authorization/revocation, and if not the patient, a description of their legal authority for authorization/revocation, and their phone number.)

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____ _____. If I fail to specify an expiration date, event, or condition, this authorization will **expire in one (1) year.**

I understand that I may refuse to sign this authorization and that, in this instance; my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

CHKDHS IS REQUIRED TO GIVE PATIENT/LEGAL GUARDIAN A COPY OF THIS AUTHORIZATION.

I certify that I am the patient, the patient's parent or legal guardian with the authority to authorize disclosure of this patient's protected health information.

_____
PRINT NAME OF PATIENT/LEGAL GUARDIAN

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

_____
RELATIONSHIP TO PATIENT/LEGAL AUTHORITY

SPORTS PERFORMANCE ACADEMY

FITNESS. STRENGTH. WELLNESS.

Fitness and Sports Performance Programs

Name of Participant: _____ DOB: _____

Address: _____ City: _____ ST: ___ Zip: _____

Parent/Guardian: _____ (H) Phone _____ (C) _____

Email Address: _____

List of sports: _____

List any previous injuries: _____

List any health-related conditions/medications (ie, diabetes, asthma, allergies etc.): _____

_____

Emergency Contacts and Insurance Information

Emergency Contact: _____ Relation: _____ Phone: _____

Second Emergency Contact: _____ Relation: _____ Phone: _____

Consent and Waiver Agreement

The Children's Hospital of the King's Daughters (CHKD) fitness and sports performance programs (the "Program") are designed to improve a participant's physical condition, and prepare him for sport participation in a safe, progressive manner. CHKD and its affiliates are not responsible or liable for any injuries resulting from Participant's participation in the Program. I understand that there is risk of injury associated with physical activity, and by signing this agreement, I consent to Participant's participation in the Program, assume all risks incidental to Participant's participation in the Program, and accept full responsibility for any injuries incurred while participating in this Program. Participant, and any parent or legal guardian acting on behalf of Participant, hereby waives, releases, and agrees to hold CHKD and any of its affiliates, and their officers, agents, and representatives harmless from all claims and liabilities of any kind arising directly or indirectly out of Participant's participation in the Program.

Authorizations and Disclosure of Information Regarding Fitness and Training Activities

As a voluntary Participant in this Program, I hereby authorize the Program and its employees and trainers to provide various fitness and training activities designed to improve my physical condition and prepare me for sport participation in a safe, progressive manner. I further authorize the Program and its employees to disclose information about my condition and progress relating to the fitness and training activities to the following individual, team organizations, or team coach, at their request:

_____

_____

Parent or guardian signature is required for each participant under 18 years of age.

By signing below, I confirm that I have read, understand, and agree to the terms and conditions of this Consent and Waiver Agreement.

_____ _____

Signature of Participant Date

If the participant is under 18: By signing below, I confirm that I have read, understand, and agree to the terms and conditions of this Consent and Waiver Agreement. By signing below, I also give my permission for the minor named above to participate in the Program.

_____ _____

Signature of Parent or Legal Guardian Date

A Pt/Phys Email/Texting

0 0 8 4 8

Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA 23507-1910

PATIENT/HEALTH CARE PROVIDER E-MAIL/TEXTING CONSENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

1. RISKS OF USING E-MAIL AND TEXT MESSAGING

CHKDHS and CSG offer patients/parents/legal guardians the opportunity to communicate by e-mail or text messaging. **Using e-mail to discuss patient information, however, is different than phone messaging. Text messaging is not to be used to convey medical information or to discuss medical conditions**. E-mail/ text message communication has a number of possible risks that patients/parents/legal guardians should consider before using e-mail/ text messaging. If the patient/parent/legal guardian is worried about any information being seen by other people, or if the question or problem is urgent, then other form(s) of communication such as telephone communication should be used. **Some of the possible risks of using e-mail/ text messaging include, but are not limited to, the following:**

a. E-mails/ text messages may be sent on to other people, stored on a computer, or printed out on paper for storage.
b. E-mails/ text messages can be sent out and received by many recipients, some or all of whom may be sent the e-mail/text message accidentally.
c. E-mail/ text message senders may easily misaddress their message.
d. E-mail/ text message information is easier to change than handwritten or signed documents.
e. E-mail/ text message information may be kept on computers/electronic devices even after the sender or the recipient believes they deleted their copy.
f. Employers and on-line services have a right to archive/ store and look at e-mails/text messages transmitted through their systems. Some, but not all, employers store e-mail/text messages indefinitely.
g. E-mails/text messages may occasionally be intercepted, changed, forwarded, or used without authorization or detection.
h. E-mails/ text messages may be used to introduce viruses into computer systems.
i. E-mails/ text messages may be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL AND TEXT MESSAGING

The health care provider (Provider)/provider's practice (Practice) will use reasonable means to protect the security and confidentiality of e-mail/text message information sent and received. However, because of the risks outlined above, the **Provider/Practice cannot guarantee the security and confidentiality (privacy) of e-mail/text messaging communication and will not be liable** for improper use and/or disclosure of confidential information (including protected health information (PHI)) that is the subject of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Thus, the patient/parent/legal guardian **must consent** to the use of e-mail/text messaging for patient information. Consent to the use of e-mail/text messaging includes agreement with the following Conditions:

a. E-mails to or from or texts messages from the patient/parent/legal guardian concerning diagnosis or treatment will be printed out and/or made part of the patient's medical record. Because they are then a part of the medical record, other individuals who are authorized to view the medical record, such as staff and billing workforce members, will also have access to those e- mails/text messages.
b. The Provider/Practice may forward e-mails/text messages internally to other staff or agents of the Provider/ Practice as necessary for diagnosis, treatment, reimbursement, and other operations. The Provider/Practice will not, however, forward e-mail or text messages to independent third parties outside of CHKDHS or CSG who are not involved with the patient's treatment, reimbursement, or otherwise involved in their care, without the patient/parent/legal guardian's prior written consent, except as authorized or required by law. The Provider/Practice may possibly forward e-mails/text messages to other health care providers participating in the patient's care.
c. Although the Provider/Practice will try to read and respond quickly to an e-mail from the patient/parent/legal guardian, the Provider/Practice cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. The usual period of time is less than one (1) business day, but it may take up to a week or longer if the individual to whom the e-mail is sent is away or if the e-mail system is not working. Thus, the patient/parent/legal guardian **should not use e-mail for medical emergencies or other matters that have to be handled quickly**.
d. Text messages are used by the Provider/Practice for appointment reminders or to share more generic information. When text messages are sent by a patient/parent/legal guardian there should not be an expectation of a response from the Provider/Practice.
e. If the patient/parent/legal guardian's e-mail requires or invites a response from the Provider/Practice, and the patient/parent/legal guardian has not received a response within a reasonable time period, it is the patient//parent/

legal guardian's responsibility to call the Practice in order to determine whether the intended recipient received the e-mail and when the recipient will respond. As an alternative, the patient/parent/legal guardian may discuss the issue by telephone.

f. The patient/parent/legal guardian should not use e-mail/ text messages to discuss any subjects that the patient/parent/legal guardian feels should be kept confidential, such as sensitive medical information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
g. Where applicable, there may be a Provider charge for the time necessary to respond to the e-mail/text message.
h. The patient/parent/legal guardian is responsible for protecting their password or other means of access to e-mail/ text messaging. The Provider/Practice is not liable for information that is read by other people through errors caused by the patient/parent/legal guardian or any third party.
i. The Provider/Practice cannot engage in e-mail/ text message communication that is unlawful, such as practicing medicine across state lines.
j. If through e-mail/ text message communication, the Provider determines that an office or hospital visit is necessary to address the problem, or if the patient/parent/legal guardian wants to have such a visit, it is the patient/parent/legal guardian's responsibility to schedule the appointment.

3. INSTRUCTIONS

To communicate by e-mail/ text message, the patient/parent/legal guardian is advised to:

a. Limit or avoid use of their employer's computer. Information is often stored on the employers system and may be read by people within that organization.
b. Inform the Provider/Practice of changes in e-mail/ text messaging addresses.
c. Help the Provider/ Practice ensure that they are communicating about the right person, put the patient's full name and date of birth in the body of the **first** e-mail message to the provider and/or practice and **not** in the subject line.
d. In order for the e-mail to be forwarded to the proper individual, include the category of the communication in the e-mail's subject line, (e.g., "I have a laboratory test question"). For instance, a billing question sent to the Provider may be forwarded to the Practice Manager.
e. Review the e-mail/ text message to make sure it is clear and that all needed information is provided before sending to the Provider/ Practice.
f. E-mails from the Provider/Practice will be **encrypted**. The first time you receive an email you will get a notice email from ZixCorp and you will have to set up your user name and password with them. This user name and password will be required to access the first and all future emails.
g. Take precautions to preserve the confidentiality of e-mails/text messages, such as using screen savers and safeguarding computer passwords.
h. Withdraw consent only by e-mail or written communication to the Provider/ Practice.
i. Contact the Provider/ Practice at their provided telephone number with any questions about using e-mail/text messaging. This should be done before sending an e-mail/text message to the Provider/ Practice.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the Provider/ Practice has provided me regarding the risks of using e-mail/ text messaging. I understand the risks associated with the communication of e-mail/ text messages between the Provider/ Practice and me, and consent to the Conditions outlined above. In addition, I agree to the above instructions, as well as any other instructions that the Provider/ Practice may impose regarding e-mail/ text message communications.

E-mail address:_____ Cell phone number for texting:_____

Print Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____ Time:_____

Witness Signature: _____ Print name:_____ Date: _____ Time:_____

Office use only:

Second Witness Signature (verbal consent only): Date: Time:_____

0 0 8 2 5

Health System

PATIENT NAME (PLEASE PRINT)

DATE OF BIRTH MR#

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Authorization to Disclose Protected Health Information Through the Use of Photography, Video/Audio Recording, and/or Interviewing

I AUTHORIZE: Children's Hospital of The King's Daughters Health System, Inc. (CHKDHS) 601 Children's Lane, Norfolk, VA 23507-1910

TO DISCLOSE: Medical information about care, treatment and diagnosis on the patient identified above including the use of photography, video/audio recording and/or interviewing

FOR THESE PURPOSES: Communication, education, promotion, public relations, marketing and/or fundraising

TO:

- CHKDHS publications and websites, including, but not limited to *Kidstuff* magazine, CHKD.org and social media outlets
- Scientific, healthcare and/or educational publications and presentations
- Public media outlets, including, but not limited to, The Virginian-Pilot, The Daily Press, The Associated Press, WTKR-TV, WVEC-TV, WAVY-TV and other local, regional, national and international print, broadcast and Internet media
- Other person/entity approved by CHKDHS

EXCEPTIONS: Please identify any exceptions to the above _____

I understand any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. ***(The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.)***

I understand I may revoke this authorization at any time, except to the extent action has been taken in response to this authorization. I understand if I revoke this authorization, I must do so in writing and present my written revocation to CHKD Marketing/PR Department, 601 Children's Lane, Norfolk, VA 23507. ***(The written revocation must include the patient's name, date of birth, revocation effective date, the legally authorized requestor's name, address, phone number, and signature with relationship to the patient.)***

Unless otherwise revoked, this authorization will expire in the event Children's Hospital of The King's Daughters Health System, Inc. ceases to exist.

Any restriction by the patient/legal guardian should be noted and initialed on this document.

I understand:

- CHKDHS will NOT receive payment as a result of using/disclosing this information for marketing purposes.
- I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.
- I will receive a copy of this document.

I certify I am the patient, the patient's parent, or legal guardian with the legal right to authorize the disclosure of this patient's protected health information.

NAME OF PARENT/LEGAL GUARDIAN OR PATIENT IF OVER 18 (PLEASE PRINT) DATE TIME

SIGNATURE OF PARENT/LEGAL GUARDIAN OR PATIENT IF OVER 18 RELATIONSHIP TO PATIENT

EMAIL ADDRESS TELEPHONE (DAY/EVENING)

STAFF USE: _____

DATE TIME STAFF NAME AND SIGNATURE