





The Pediatric Center

## Consent Form

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

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.

**I understand that my insurance company may decide ImPACT is not a covered expense and may therefore deny payment. Alternatively, they may apply the charges to a deductible plan. In either case I understand that I will be responsible for all charges related to this test.**

**Printed Name of Athlete** \_\_\_\_\_

**Sport** \_\_\_\_\_

Signature of Athlete \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_

Date \_\_\_\_\_