

May 1, 2009

Dear Parent/Guardian of Student-Athlete,

On behalf of Villanova Sports Medicine I would like to inform you of the services that will be provided to your son or daughter while they participate in athletics at Villanova University. As you know, inherent risks are associated with playing sports and it is crucial that we communicate the policies and procedures that we operate under in order to appropriately handle these injuries when they occur.

A long-standing University policy requires that all student-athletes provide evidence of insurance that includes coverage for athletically-related injuries and must have a limit of at least \$75,000. This is a pre-requisite for all practices and competitions. Students are not allowed to participate until evidence of current insurance coverage is on file with the Villanova University Department of Sports Medicine. Enclosed you will find an Emergency Contact and Insurance Information form that acknowledges that you understand this policy and that your insurance meets these requirements. Please make sure that you read and complete this form and return it in the enclosed self-addressed stamped envelope with a photocopy of both sides of your insurance card. If your insurance does not meet these requirements, we will review the individual circumstances to determine if the insurance meets the insurance coverage requirement.

All medical treatment for an injury or illness must begin with a Villanova University Athletic Trainer and/or Team Physician. Any medical treatment engaged, and the expenses associated with treatment, without the explicit knowledge or approval from the Sports Medicine Department will be the financial responsibility of the student-athlete and/or their family. All medical bills must be submitted first to the student athlete's primary insurance (this is completed by the provider of medical service).

The Athletic Department maintains a secondary insurance policy to supplement costs not covered by a student-athlete's primary insurance. The secondary policy provides medical expense benefits for accidents or injuries directly related to a student-athlete's participation in a scheduled and sponsored practice or competition while directly representing Villanova University Athletics. Not all medical expenses incurred by the athlete are payable by this policy, so please check with the Sports Medicine Staff should you have any questions about your coverage.

As balance due billings are sent to the student-athlete and/or their primary residence, these charges must be sent to the Sports Medicine Department along with primary insurance explanation of benefits so that the school may process the payment immediately. Please do not ignore medical bills as this may result in future involvement with collection agencies and negative credit. There are certain policy restrictions, limitations and exclusions for payment. Please be advised to communicate any medical treatment and to present all medical bills and paperwork so they may be processed for payment eligibility as soon as possible.

Villanova University Sports Medicine is committed to providing its student-athletes with the highest level of care. We appreciate your acknowledgement and understanding by completing all enclosed paperwork and returning it to Villanova Sports Medicine as soon as possible. Please contact me if you have any questions regarding this information.

Sincerely,

Lenny Currier
Director of Sports Medicine
Villanova University
(O) 610-519-5669
(F) 610-519-7728

VILLANOVA SPORTS MEDICINE
Health Insurance/ Emergency Contact Information

Athlete's Name: _____ Gender: _____ Sport: _____

Soc Sec #: _____ Date of Birth: _____ Cell Phone #: _____

Home Phone #: _____ Academic Year: 1 2 3 4 5

Athlete's Permanent Address: _____

EMERGENCY CONTACTS

Primary Contact

Name: _____ Relation: _____

Address: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Secondary Contact

Name: _____ Relation: _____

Address: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

INSURANCE INFORMATION

Company: _____

Address: _____

Phone #: _____ Policy Type: HMO PPO

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holders Soc. Sec. # _____

Policy Holder's Date of Birth _____ Precertification Needed: Yes No

Primary Care Physician _____ Physician's Phone # _____

Referral Needed: Yes No



I, _____, as parent, guardian or legal representative, attest that
(parent, please print)

_____ DOES/DOES NOT (circle one) have insurance coverage
(student-athlete name) under a current, in force insurance policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has limits of at least \$75,000 and is valid in the state of Pennsylvania. **If there is a material change in coverage or expiration of coverage, I agree to notify Villanova University of this development and update the insurance information I have on file.** I understand and agree that Villanova University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Villanova University.

(signature)

(date)

PLEASE INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD.

Return to:

Villanova University
Sports Medicine
Jake Nevin Field House
Villanova, PA 19085
(O) 610-519-5669
(F) 610-519-7728



Bryn Mawr Sports Medicine

**Orthopaedic Specialists, P.C.
Bryn Mawr Sports Medicine**

- 27 South Bryn Mawr Avenue
Bryn Mawr PA 19010-3406
(610) 527-2727
(610) 527-1588 fax

- Two Devon Square
744 W. Lancaster Avenue
Suite 125
Wayne, PA 19087-2523
610-586-6767
610-688-3224 Fax

William D. Emper, M.D.
Joseph L. Eremus, M.D.
Robert P. Good, M.D.
Matthew P. Lorei, M.D.

*Joint Replacement
Sports Medicine
Arthroscopy
Disorders of the Elbow & Shoulder
Disorders of the Foot & Ankle
Fractures/Trauma*

Kevin M. Walsh, M.D.
Primary Care Sports Medicine

Hand Surgical Associates

- Bryn Mawr Medical Office Bldg, North
830 Old Lancaster Road, Suite 300
Bryn Mawr PA 19010
(610) 527-9000
(610) 520-0645 fax

William H. Kirkpatrick, M.D.
Jack Abboudi, M.D.

*Surgery and Rehabilitation of the
Hand and Upper Extremity*

Orthopaedic Consultant
Vincent J. DiStefano, M.D.

Dear Parent/Guardian:

Your son or daughter may require treatment by Orthopaedic Specialists, P.C. - Hand Surgical Associates.

Orthopaedic Specialists - Hand Surgical Associates will bill your medical insurance first. You are responsible to provide us with a copy of your insurance card (front and back) as well as obtaining any referrals that your insurance may require. If your insurance company is out-of-network and sends payment to you – please forward the payment as well as the explanation of benefits to Orthopaedic Specialists, P.C. - Hand Surgical Associates, 27 South Bryn Mawr Ave., Bryn Mawr, PA 19010.

Orthopaedic Specialists - Hand Surgical Associates will bill AG Administrators for any balances after your medical insurance processes the claim, as long as we have a completed AG Administrators form, indicating the treatment was sports related.

Please complete the attached insurance information sheet. Please be sure to provide us with all requested information, especially parent/guardian date of birth - without this information we will be unable to bill most insurance companies, and subsequently the bill will be sent to you.

If you have any questions you may contact our billing department @ 610-527-6428.

I give my son/daughter permission to be treated by Orthopaedic Specialist, P.C. - Hand Surgical Associates.

I acknowledge the receipt of Orthopaedic Specialists, P.C. - Hand Surgical Associates notice of Privacy Practices. (HIPPA).

_____ Date _____
(student name - please print)

_____ Date _____
(parent signature)

VILLANOVA

SPORTS MEDICINE

Returning Athlete Physical

Name: _____ Sport: _____ Date: ___/___/___

Please list any current conditions:

Orthopedic

General Med.

Do you wish to see a physician for any of the above listed conditions? Yes / No

Are you currently taking any medication? Yes / No

- Are you currently taking Birth Control? Yes / No
- Are you currently using supplements/Vitamins? Yes / No

Do you have any known allergies? Yes / No

Do you currently use any prescription eyewear? Yes / No

- Have there been any changes to your prescription? Yes / No

Have you been hospitalized or had surgery? Yes / No

Are you currently in care of a physician? Yes / No

Please explain any "yes" from above: _____

Are you able to participate at "Full Go" status? Yes / No

BP: _____ Pulse: _____ Height: _____ Weight: _____

Athlete's Signature: _____ Date: ___/___/___

Athletic Trainer's Signature: _____ Date: ___/___/___

Send this claim form, PRIMARY INSURANCE EXPLANATIONS OF BENEFITS, and ITEMIZED BILLS to:

A-G Administrators
SPORTS INSURANCE SPECIALISTS
P.O. BOX 979, VALLEY FORGE, PA 19482

QUESTIONS?
Call 800-752-2008 PA
800-634-8628

Please Print

STUDENT'S SOCIAL SECURITY NUMBER

TO BE COMPLETED BY THE STUDENT

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College or University _____

Student's Name _____ Sex Male Female
FIRST NAME MIDDLE INITIAL LAST NAME

Student's School Address _____
STREET CITY STATE ZIP

Student's Home Address _____
STREET CITY STATE ZIP

Phone Numbers _____ Date of Birth _____
AT SCHOOL HOME

AUTHORIZATION

I AUTHORIZE ANY PHYSICIAN AND/OR HOSPITAL TO RELEASE SUCH INFORMATION AS RELATES TO THIS CLAIM TO A-G ADMINISTRATORS, INC.

SIGNATURE _____ DATE _____

TO BE COMPLETED BY SCHOOL OFFICIAL

WHICH SPORT? _____ DATE & TIME _____

TYPE OF INJURY: INTERCOLLEGIATE CLUB SPORT INTRAMURAL

CIRCUMSTANCE: GAME PRACTICE CONDITIONING

PLACE OF ACCIDENT: _____

BODY PART INJURED: _____

NATURE OF INJURY — DETAILS OF WHAT HAPPENED: _____

Are you aware of any other insurance program covering this athlete? Y N Ins. Co. Name _____

Please attach a copy of Insurance Verification Form.

I certify that the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.

SIGNATURE OF ATHLETIC DEPARTMENT OFFICIAL TITLE DATE

MUST BE SIGNED BY SCHOOL ATHLETIC OFFICIAL