CLIENT DETAILS & CLEARANCE FORM

The information obtained will be treated as confidential and will not be released or revealed to any person without your written consent. The information obtained may be used for statistical or scientific purpose with your right of privacy retained.

How did you hear about us?

☐ Internet search ☐ Social media ☐ Word of mouth ☐ GP/Specialist ☐ Other

INFORMATION

Name: _____ Age: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Email: _____

THIRD PARTY DETAILS

Medicare#: _____ IRN: _____

Private Health#: _____ IRN: _____

Dept. Veteran Affairs (DVA)#: _____ Card type (please tick): ☐ White ☐ Gold

MULTIDISCIPLINARY MEDICAL PROFESSIONAL DETAILS

➢ Do you consult a regular GP? If so, please provide details below.

GP Name: _____ Practice: _____

➢ If you are currently consulting a specialist, please provide details below.

Specialist Name: _____ Practice: _____

Specialty: _____

➢ If you are currently consulting other allied health professionals, please provide details below.

☐ Physiotherapist ☐ Dietitian ☐ Psychologist

☐ Chiropractor ☐ Osteopath ☐ Other

☐ Diabetes Educator ☐ Podiatrist

Name: _____ Practice: _____

Name: _____ Practice: _____

CURRENT MEDICATIONS/SUPPLEMENTS

Please list any medications or supplements you are currently taking or prescribed:

_____

HEALTH & FITNESS GOALS

What are your health and fitness goals and objectives?

_____

OPERATIVE

Are you pre or post-operative? (please tick): ☐ Yes ☐ No

Area/type of surgery? _____

When is/was the date of surgery? _____

ESSA PRE-EXERCISE & CURRENT HEALTH SCREENING

Have you ever had or do you currently have any of the conditions below? (please tick)

- Has your doctor said you have a heart condition or have you suffered a stroke? ☐ Yes ☐ No
  If yes, please specify: _____
- Do you have a family history of heart condition or stroke? ☐ Yes ☐ No
  If yes, please specify: _____
- High blood pressure? ☐ Yes ☐ No
- High cholesterol or triglycerides? ☐ Yes ☐ No
- Are you a smoker? ☐ Yes ☐ No
- Do you experience unexplained chest pain at rest or during physical activity? ☐ Yes ☐ No
- Do you feel faint or have dizziness during physical activity that causes loss of balance? ☐ Yes ☐ No
- Have you experienced a fall in the last 12 months? ☐ Yes ☐ No
  If yes, please specify _____
- Do you experience breathing difficulties or have you had an asthma attack requiring medical attention over the last 12 months? ☐ Yes ☐ No
- Do you have type 1 or type 2 diabetes? ☐ Yes ☐ No
  If yes, have you had trouble controlling your glucose levels in the last 3 months? ☐ Yes ☐ No
- Do you have a diagnosed muscle, bone or joint problems that may worsen when participating in physical activity? ☐ Yes ☐ No
  If yes, please specify: _____
- Arthritis (Osteoarthritis/Rheumatoid)? ☐ Yes ☐ No
- Back pain/discomfort? ☐ Yes ☐ No
- Muscular/Joint/Ligament/Tendon injury? ☐ Yes ☐ No
  If yes, please specify: _____
- Chronic pain? ☐ Yes ☐ No
- Mental illness? ☐ Yes ☐ No
  If yes, please specify: _____
- Cancer? ☐ Yes ☐ No
  If yes, please specify current treatment circumstances: _____
- Rheumatic fever? ☐ Yes ☐ No
- Gout? ☐ Yes ☐ No
- Stomach/Duodenal ulcer? ☐ Yes ☐ No
- Hernia? ☐ Yes ☐ No
- Liver/Kidney condition or disease? ☐ Yes ☐ No
- Epilepsy? ☐ Yes ☐ No
- Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity? ☐ Yes ☐ No

If yes, please specify: _____

If you have experienced any conditions/injuries not listed above, please specify below:

_____

_____

_____

525 Stirling Highway Cottesloe WA 6010 ph: (08) 9385 1430
w: chroniccare.com.au e: admin@chroniccare.com.au
Chronic Care Australia PTY LTD — ACN: 622 160 070

CLEARANCE FORM

ALLIED HEALTH PROVIDER:
Elite Health Management PTY LTD (trading as The Exercise Therapist) and Chronic Care Australia

PARTICIPANTS NAME: _____ **AGE:** _____

***(If under 18 years, parent/guardian to also sign)*

WARNING AND ACKNOWLEDGMENT OF RISKS, INJURY AND OBLIGATIONS

In signing this contract you recognise and accept that some of the treatments you receive may cause injury.

YOU NEED TO LET US KNOW

Please inform your Allied Health Professional if you have –

- A pacemaker or heart condition
- Suffered from blood clots
- Thrombosis or stroke
- Suffer from diabetes
- Are currently taking medication

ACKNOWLEDGEMENT

I Acknowledge that the activity I am to undertake, be it In-Person or Virtual, may be a dangerous activity that may involve a risk of physical harm (the "activity") and that by participating in it I am exposing myself to potential risks.
I further acknowledge that I am participating in the activity voluntarily.

RELEASE, INDEMNITY AND DISCLAIMER

In consideration of my payment for participating in the activity **I agree to release and indemnify** ELITE HEALTH MANAGEMENT PTY LTD (Trading as THE EXERCISE THERAPIST) and CHRONIC CARE AUSTRALIA PTY LTD (Trading as Chronic Care Australia) servants, agents, and employees in that:

1. I participate in the activity at my own risk and responsibility.

2. I release and hold ELITE HEALTH MANAGEMENT PTY LTD (Trading as THE EXERCISE THERAPIST) and CHRONIC CARE AUSTRALIA PTY LTD (Trading as Chronic Care Australia), its servants and agents, from and against all actions or claims which may be made by me or on my behalf arising out of any injury, loss, damage or death caused to me or my property in any manner whatsoever including if such injuries, loss and damage are caused by negligence and or breach of any statutory duty.

BEFORE SIGNING THIS DOCUMENT:

- I have read and understood it and know that it affects my legal rights
- The above represents and warrants to ELITE HEALTH MANAGEMENT PTY LTD (trading as The Exercise Therapist) and CHRONIC CARE AUSTRALIA that I have disclosed all details or any medical condition I have and of all recent medical treatment received by me

Appointment reminders are sent one day prior, please tick preferred option:	☐ SMS ☐ Email
I would like to receive important clinic communications, research articles and promotions via email:	☐ Yes ☐ No

Your Name: _____ Sign: _____ Date: _____

The Exercise Therapist Witness: _____ Sign: _____ Date: _____

TERMS & CONDITIONS

THE EXERCISE THERAPIST

Offers wellness and physical activity services. Its services were designed to help clients continue on wellness continuum after clinical treatment. It also offers general fitness and motivational mindset services, products and programs.

CHRONIC CARE AUSTRALIA

Offers clinical services for the prevention, treatment and management of chronic health conditions, including but not limited to cancer, heart disease, mental health, osteoarthritis, back pain, lung disease and diabetes plus pre and post-operative and women's health services.

OFFICE HOURS

If the office is unattended, please leave your name and return phone number and we will call you back as soon as possible. If you are in need of emergency attention, please call your GP or attend a hospital Emergency Department.

Monday – Friday: 6:00am – 6:00pm

Saturday and Sunday: Closed

APPOINTMENTS AND CANCELLATIONS

Follow up appointments should be scheduled in advance where possible. We will endeavour to give you a reminder the day before the appointment, however if you are unable to keep the scheduled appointment please contact our office as soon as possible to cancel.

Due to high demand of appointments, we have introduced a 50% non-attendance fee which is implemented if the appointment is cancelled on the day of scheduled appointment. No fee will be charged if the appointment is cancelled at or before 6pm the previous day. Any voicemail and email messages left within time boundaries will be seen as early notifications for cancellations.

REFERRAL LETTER

For all Medicare clients, you are required to obtain a letter of referral from your GP. This letter is necessary for you to claim the Medicare rebate and is valid for 12 months. If your referral is from a specialist this is valid for 3 months only. If you change to a new GP please obtain a new referral. This will ensure that your new GP is advised of your progress. We will endeavour to remind you when your referral is due to expire, however it is your responsibility to ensure that your referral is current. Please scan and email your referral to admin@chroniccare.com.au

We are clinically bound to reporting all CDM & TCA referrals. A report cost will be charged to generate these reports. You must have your referral with you or emailed to us ahead of your scheduled appointment.

YOUR DETAILS

Please advise reception if you have any changes to your details, i.e. change of address, phone number, emergency contact, change of health fund etc.

REFUNDS

We do not provide refunds on Chronic Care Australia programs or The Exercise Therapist services (this includes private consultations and group training programs), however, will allow discussion and review of specific circumstances with the Director of The Exercise Therapist.

PRIVATE HEALTH INSURANCE

In order to receive a rebate from your private health insurer, the treatment must aim to prevent, delay or ameliorate a chronic condition or injury. To ensure the rebate is accepted, you must nominate exercise physiology as one of your preferred cover inclusions within Allied Health Providers. Claims can be made now on site at The Exercise Therapist using a HICAPS machine for both group and individual purchases. For post-purchase claims, you will need to go into your chosen insurance provider outlet or mail your claim into the insurance provider. Processes for claims by mail vary from one health provider to another, so please call your health fund for specific details. All appointments on a CDM plan can only be made after receipt of referral, and you will be unable to backdate claims.

At The Exercise Therapist we support HBF Health Limited as our health fund of choice. Other health funds that pay benefits for both group and individual include CBHS Health Fund Limited, Garrison Health, HCF, Health Partners, Mildura District Hospital Fund Ltd, Queensland Country Health Fund Ltd, St Luke's Health, Teachers Health Fund, TUH and Westfund Limited.

FEES

Please refer to our website www.theexercisetherapist.com for a list of our fees.

For our clients that are currently on the permanent schedule, and have regular sessions per week using a 5, 10 or 20 pack of sessions, you will receive a courtesy email when you have 2 sessions remaining from your current pack, as well as an invoice for a new 10 or 20 pack of sessions. Once all of your sessions have been completed, another email will be sent containing a receipt of completion, for private health claiming purposes.

CHRONIC CARE AUSTRALIA

Our Chronic Care Australia programs are prescribed on an 8 or 12-week basis and are time-based rather than session-based. Please note that treatment program will only be extended for a maximum of two weeks due to illness or holidays (if advised in advance) to make up for missed sessions. Please contact admin to arrange a time to make up for missed sessions. Expiry of our casual 10 pack sessions are in-line with current Australian Government laws for Business.

Please ensure to notify staff of any upcoming absences due to holidays, treatments, surgery or otherwise and book in a session for your returning date.

Please contact us for further information about our chronic illness and disease management programs.

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