

# 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 \_\_\_\_\_

## PERSONAL 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 circle): 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: \_\_\_\_\_

Speciality: \_\_\_\_\_

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

- |  |                                     |                                       |
|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Physiotherapist   | <input type="checkbox"/> Dietician  | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Osteopath  | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Diabetes Educator | <input type="checkbox"/> 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?  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?

<ul style="list-style-type: none"> <li>Has your doctor said you have a heart condition or have you suffered a stroke? If yes, please specify:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you have a family history of heart condition or stroke? If yes, please specify:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>High blood pressure</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>High cholesterol or triglycerides</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Are you a smoker?</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you experience unexplained chest pain at rest or during physical activity?</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you feel faint or have dizziness during physical activity that causes loss of balance?</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Have you experienced a fall in the last 12 months If yes, please specify:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you experience breathing difficulties or have you had an asthma attack requiring medical attention over the last 12 months?</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you have type 1 or type 2 diabetes If yes, have you had trouble controlling your glucose levels in the last 3 months? Yes / No</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you have a diagnosed muscle, bone or joint problems that may worsen when participating in physical activity? If yes, please specify:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Arthritis (Osteoarthritis/Rheumatoid)</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Back pain/discomfort</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Muscular/Joint/Ligament/Tendon injury If yes, please specify:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Chronic pain</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Mental illness If yes, please specify:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Cancer If yes, please specify current treatment circumstances:</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Rheumatic fever</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Gout</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Stomach/Duodenal ulcer</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Hernia</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Liver/Kidney condition or disease</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Epilepsy</li> </ul>	Yes	No
<ul style="list-style-type: none"> <li>Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity? If yes, please specify:</li> </ul>	Yes	No

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

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## 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: \_\_\_\_\_



**CHRONIC CARE AUSTRALIA**

**Reducing the burden of chronic conditions  
so all Australians can live well for longer.**

+ 21 Stuart Street, Mosman Park WA, 6012 + ph: (08) 9385 1430 + w: chroniccare.com.au  
+ Chronic Care Australia PTY LTD – ACN: 622 160 070

# Terms & Conditions

<b>The Exercise Therapist</b> 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.	<b>Chronic Care Australia</b> 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 & post-operative and women's health services.
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## Office hours:

If the office is un-attended, 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](mailto: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, discussion and review of specific circumstances presented to the manager of Chronic Care Australia and The Exercise Therapist will be reviewed with compassionate plus medical consideration.



### 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](http://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.



- Are you involved in a CCA Pilot Program?
  - Yes, please read and sign the below statement
  - No

I, \_\_\_\_\_ have read the information provided and any questions I have asked have been answered to my satisfaction. I agree to participate in this pilot project. And, I understand that withdrawal is not possible once data is submitted.

I understand that all identifiable information that I provide is treated as confidential and will not be released by the investigator in any form that may identify me unless I have consented to this. Separate to this agreement all data is de-identified and stored securely.

The only exception to this principle of confidentiality is if this information is required by law to be released.

Approval to conduct this pilot project has been provided by the Chronic Care Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this pilot project, or agreeing to participate, may raise any questions or issues with the Chronic Care Australia at any time.

In addition, any person not satisfied with the response of Chronic Care Australia may raise ethics issues or concerns, and may make any complaints about this pilot project by contacting the Chronic Care Australia Practice Manager by emailing to [Manager@chroniccare.com.au](mailto:Manager@chroniccare.com.au)

All pilot participants are entitled to retain a copy of any Participants Information Form and/or Participant Consent Form relating to this pilot project.

\_\_\_\_\_  
Participant signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

