Physiotherapy Mat Pilates Enrolment Form

PERSONAL DETAILS:

Name:		***DOB:***	
Address:		***Postcode:***	
Phone:	***(m)***	***(h)***	***(w)***
Email:		***Occupation:***	
Emergency Contact:		***Emergency Contact Phone:***	
Do you have any Private Health Insurance (eg Medibank, HBF)?			Y / N
Indicate Fund:			_____

How did you hear about Pilates at Bodysmart Health Centre?

☐ Search Engine ☐ Yellow Pages ☐ Workplace Expo ☐ Flyer - Workplace
☐ Newsletter ☐ Internet Search ☐ Health Insurance Website ☐ Ergonomic Assessment
☐ Doctor (Please specify) _____
☐ Friend /Colleague **(please specify name)** _____
☐ Other (Please specify) _____

Would you like to receive our FREE monthly health and wellbeing e-bulletin? Yes ☐ No ☐
Would you like to receive a link to our Facebook page (offers / discounts advertised)? Yes ☐ No ☐

EXERCISE HISTORY

Have you been exercising regularly? (Please circle) YES | NO

(a) If yes, please provide details of the following:

* Type of exercise_____
* Frequency of exercise_____
* Your perceived intensity when exercising? Hard | Medium | Light | Very Light

(b) If no, approximate date you last exercised regularly?_____

MEDICAL CONDITIONS

Did a medical practitioner / health care professional recommend that you commence Pilates? If so please provide details: Name and Specialty_____

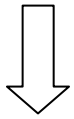
If you are female, are you pregnant or have you given birth within the last 6 months?
YES | NO – Provide Details_____

Do you suffer any of the following?

☐ Nervousness	☐ Shoulder pain	☐ Mid back pain
☐ Chronic Irritability	☐ Arm / elbow pain	☐ Rib pain
☐ Insomnia	☐ Arm weakness	☐ Low back pain
☐ Head/face pain	☐ Hand / wrist pain	☐ Ankle / foot weakness
☐ Headache	☐ Finger numbness	☐ Buttock pain
☐ Dizziness	☐ High Blood press.	☐ Leg pain
☐ Nausea / vomiting	☐ Low Blood Press.	☐ Leg weakness / numbness
☐ Eye disorder	☐ Chest pain	☐ Abdominal pain / cramp
☐ Sinusitis	☐ Indigestion	☐ Kidney disorder
☐ Asthma	☐ Foot / toe numbness	☐ Urinary problems
☐ Neck pain	☐ Calf cramping	☐ Shortness of breath

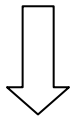
MAT PILATES PROGRAM CUSTOMISATION PROCESS

STEP 1 **30 minute 1:1 Mat Pilates Assessment** **(Required)**



Includes questionnaire of symptoms, range of movement analysis, postural review, education on core activation, understand your goals, familiarise ourselves with your issues, we introduce you to the key principles of Pilates. *This is booked under HICAPS code 506 and can be paid for on the day of the session.*

STEP 2 **1:1 Session (1 to 3+ sessions of 30 or 40 duration)** **(Optional)**



Performance of these introductory sessions will improve your confidence and ability in correctly activating the "core" and understanding of the Pilates equipment in a one on one environment under your Physiotherapist's guidance. *These sessions are booked under HICAPS code 506 and can be paid for on the day of the session.*

STEP 3 **Attend Small Group 45 minute Sessions (up to 1:6 ratio)**

One experienced Pilates Physiotherapist works a small group of with 4-6 clients simultaneously. The physiotherapist will modify exercises for each participant as required. *These sessions are booked under HICAPS code 560 and can be paid for on the day (if casual) or in packs of 5, 10 or 25.*

TERMS AND CONDITIONS

By enrolling in this course you enter into a legally binding agreement with the Exercise Class Operator -BODYSMART HEALTH SOLUTIONS PTY LTD, trading as "BODYSMART HEALTH CENTRE" and agree to comply with and adhere to the following terms and conditions:

1. Enrolment in any session will only be confirmed upon receipt of this form, duly completed together with payment of fees for the sessions enrolled in. Session availability will be filled in the order in which enrolment forms and session payments are received (i.e. 'first in, best dressed').
2. In regard to any medical condition disclosed on this form, participants undertake to obtain clearance from their medical practitioner prior to enrolling in these sessions.
3. Credits for non-used sessions will be given only in the case where a valid medical certificate is presented to Bodysmart Health Centre that is issued by a certified General Practitioner or Bodysmart Physiotherapist and at the sole discretion of Bodysmart Health Centre.
4. Non-used credits can be transferrable to another participant, if still valid; however, it is your responsibility to find a suitable replacement participant.
5. For reasons of hygiene, participants are required to bring and use a towel large enough to lie on.

6. If you are unable to make a session we ask that you give us a minimum of 24 hrs notice. Participants will be billed the normal session fee if less than 24 hrs notice is given.
7. It is the participant's responsibility to book their sessions through Bodysmart Reception via phone or email. Five, 10 and 25 pack purchases are valid for 6 weeks, 12 weeks and 8 months respectively. Any unused credit will be forfeited if not utilised within this timeframe.
8. In the interest of safety for all participants, and as class sessions are structured, those who arrive more than 10 minutes late will NOT be permitted to enter the class. The participants will not receive a refund or credit for this session.

DECLARATION

Bodysmart Physiotherapists will take utmost care to ensure your health and safety is a primary concern however we need to make you aware that exercise is not without risk to the musculoskeletal and cardiovascular systems.

I acknowledge I have voluntarily elected to participate in an exercise program with BODYSMART HEALTH CENTRE. I will not hold BODYSMART HEALTH SOLUTIONS responsible or liable for any personal injury or loss or damage which may result from my participation in any proposed exercise program with BODYSMART HEALTH SOLUTIONS.

Further, I agree to accept the above Terms and Conditions.

SIGNED:_____ DATED:_____

ENROLMENT

Please enrol me in:

☐ Initial Pilates Assessment 1:1 (required) $84 (when pack purchased) one off payment. (Pay on the day of Service)
1:1 Session (optional) 30 minute or 40minute options (based on recommendation of Physiotherapist) (Pay on the day of Service)

Small Group Mat Pilates Session Packs					
☐ Casual	$35/session (Pay on the day)		☐ 10 Pack	$280	- $28/session (Valid 3 months
☐ 5 Pack	$150	- $30/session (Valid 6 weeks)	☐ 25 Pack	$650	- $26/session (Valid 8 months)

PAYMENT

Payment via (please circle): Cash | EFTPOS | Credit

I _____authorise Bodysmart Health Solutions to deduct $_____ from my

☐ VISA ☐ MASTERCARD

Card number: **Card expiry:**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐/☐☐/☐☐

Credit card verification / CCV: *(last 3 digits on back of card)* ☐☐☐

Name on card:_____ **Signature of card holder:**_____

Please fax completed form to (08) 9481 8709 or scan and email to reception@bodysmart.com.au

MEDICAL CONSENT FORM – PHYSIOTHERAPYPREGNANCY PILATES

Dear Doctor,

Your client _____ wishes to take part in our Physiotherapy Pregnancy Pilates Program. This is a 6-week program consisting of mat based Pilate's exercises incorporating fit ball and theraband exercises supervised by a qualified Physiotherapist. We are asking all of our participants to seek medical clearance prior to starting the program to ensure there are no complications associated with their pregnancy that we need to be aware of.

Please identify any recommendations or restrictions program below.

Client's Consent and Authorization

I consent to and authorise _____ to release to _____ , health information concerning my ability to participate in an exercise program. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Clients signature:	Date

Physician's Recommendations

Indicate	
	I am not aware of any contraindications toward participation in a Pregnancy Pilates program.
	I believe the applicant can participate, but urge caution because:
	The applicant should not engage in the following activities:
	I recommend the applicant **not** participate in the Pregnancy Pilates Program because:

Physician's signature		Date
Physician's name (print)	Phone	Fax
Address:		