Iconic care PTY LTD
02 4604 8282
0474 801 695
www.iconiccaregroup.com.au
Info@iconiccaregroup.com.au

Participant Exercise Physiology Consent Form

Please read and sign the following:

Informed Consent *means that you understand your situation and the outcomes of the proposed treatment options; or lack thereof.*
Our Exercise Physiologist will discuss with you, your condition and options for treatment to ensure that you are appropriately informed and can make decisions relating to treatment. For any assessment or treatment to proceed you should understand why it is performed and give your consent after any and all questions are answered. You may refuse any form of treatment for any reason, even after you have previously given consent. The treating clinician may also refuse to treat if the treatment is deemed inappropriate and/or unsafe to the patient; or if the patient's presentation or behaviour is unhygienic, inappropriate or aggressive.

Questions of a personal nature

Your Exercise Physiologist may ask personal questions relating to your injury/illness and how your condition impacts on your participation and 'activities of daily living'. The more accurate information you provide, the more likely it is that the Exercise Physiologist can provide effective exercise. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the Exercise Physiologist know and they will cease.

Physical contact

During the examination, assessment and exercise it may be necessary for your Exercise Physiologist to make (appropriate) physical contact or request you to disrobe the affected and opposite area(s). Your Exercise Physiologist will ask your permission before making physical contact with you. Wherever possible, contact will be made through gloved hands or through a towel when screening. Patient decency will be maintained by using a towel where necessary. Physical contact and disrobing requires your express consent. You may withdraw consent at any time at which point, the session will stop immediately. Please inform your Exercise Physiologist if you feel uncomfortable at any time.

Risk related to treatment

As with all forms of treatment, there are risks and benefits. The Exercise Physiologist will discuss any foreseeable risks with you prior to commencing exercise. In some cases, the Exercise Physiologist may ask you to read information related to a particular treatment, and they may request that you sign a further consent form. This is to ensure that you fully understand any risks involved. You may withdraw your consent at any time even if you have previously signed a consent form.

Substituted Consent, or Parental/Guardian Consent

Where a person is incapable of understanding the risks and benefits of treatment - or under the legal age (14 - 18 years) and requires parental/guardian consent - consent may be provided by a "Person Responsible" - *under the NSW Mental Health Act 2007 or Minors (Property and Contracts) Act 1970, Guardianship Act 1987, Children and Young Persons (Care and Protection) Act 1998* - or a person legally authorized to provide such consent. Evidence of legal authorization is required in such circumstances; including proof of lack of mental capacity, proof of legal authority or guardianship, and proof of relationship.

You need to let us know

The risk related to some treatments can increase if the Exercise Physiologist is not aware of certain facts. Please ensure you provide complete and accurate information. The Exercise Physiologist will enquire further to assist. Importantly, please inform the Exercise Physiologist if you have a contactable/transmittable disease (e.g MRSA, HIV, Hepatitis, Covid, Cold/Flu, etc).

Please note – if after reading this page you are at all unsure of what is written, please discuss it with the Exercise Physiologist.

I, _____ have read and understood the above consent form. All my questions have been answered and I agree to these conditions of service provided to my child _____ by the Exercise Physiologist without duress.

Signature: _____ Date: _____

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Child details					
Title	Given Name		Family Name		
Date of Birth		Gender: ☐ Male ☐ Female ☐ Other			
Home Address		Suburb		Postcode	
Medicare Number			Medicare Ref #		
Name on Medicare			Expiry Date		
Health Card No.			Expiry Date		
GP Name / Address			Contact Number		
Preferred Language *Written info provided different languages via translating and interpreting services (TIS)*		Interpreter Required? ☐ Yes ☐ No ☐ Unsure			
Cultural Background	Aboriginal ☐	Torres Strait Islander ☐	Both ☐	Other (please specify)	
Does the participant (or their guardian, if applicable) have any preferences regarding their connection to their Aboriginal and Torres Strait Islander culture and community?					
Does the participant (or their guardian, if applicable) have any preferences regarding their cultural, spiritual and/or language connection?					
Does the participant (or heir guardian, if applicable) have any preferences regarding their links to family, friendships, and other support networks?					
Funding Information / Options					
Private Health Insurance	Insurance Company -				
Veterans Affairs	Card Number -				
Medicare EPC	☐ Yes ☐ No				
Worker's *Compensation*	Employer		Contact Person		
(If you are claiming CTP, please fill out the details as required)	Employers Email		Phone Number		
	Company Location (location of Injury)				
	Occupation		Date of Injury		
	Insurer	Claim No.	Case Manager		
	Insurers Address		Phone Number		
NDIS	☐ NDA Managed	☐ Plan Managed	☐ Private / Self – Managed	☐ GP Plan	
	NDIS participant Number				
	Plan Start Date		Plan End Date		
Self/Plan managed	Plan Manager				
	Plan Manager Email		Phone		

Parent/Guardian Details					
Full Name			Date of Birth		
Medicare Number		Ref #		Expiry Date	
Home Address		Suburb		Postcode	
Email address			Phone #		

Emergency Contact Details					
Full Name		Relationship to Participant			
Email Address		Contact Number			
Home Address		Suburb		Postcode	

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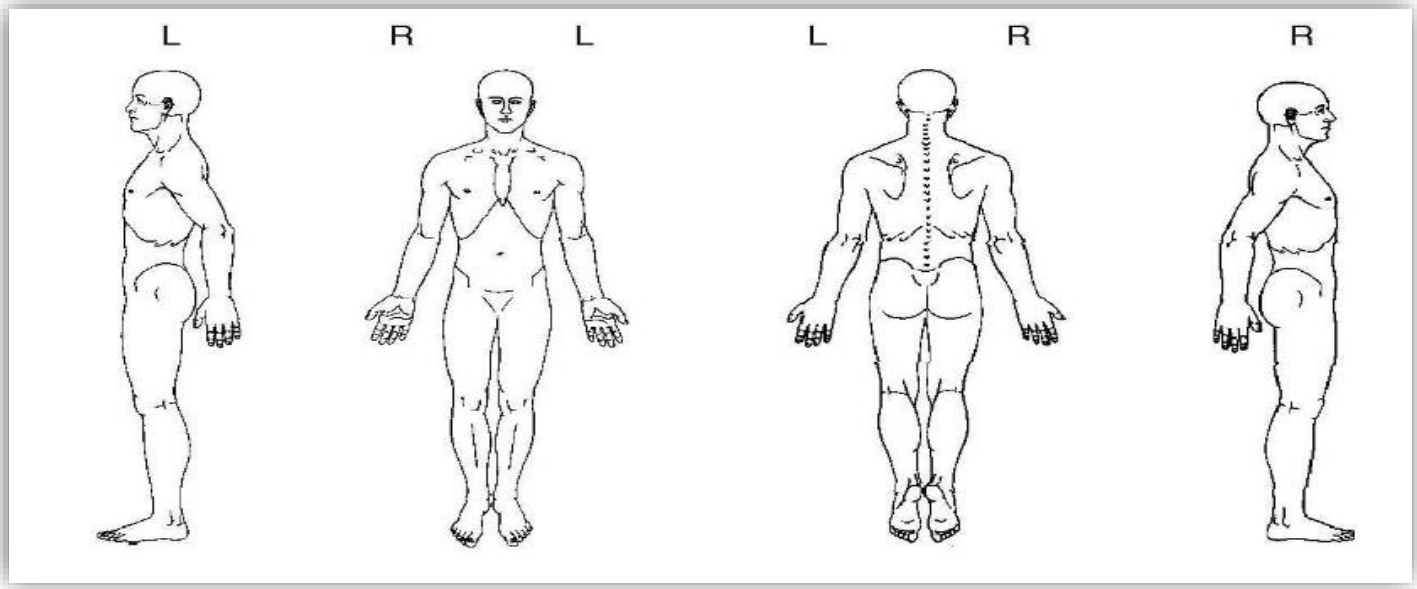
Confidential Case History

What do you hope to achieve specifically from treatment? *(Include goals and deadlines)*

Draw on the sketch below the area where you feel your problem to be.



How long have you had this problem?

Have you had this or a similar problem in the past? Yes / No

If you are experiencing pain, please tick the words that best describe your pain:

- ☐ Constant
- ☐ Comes & goes
- ☐ Sharp
- ☐ Dull Achy
- ☐ Intensity varies
- ☐ Intensity doesn't vary
- ☐ Shooting
- ☐ Radiates
- ☐ Travels

Do you get?

- ☐ Pins and needles
- ☐ Tingling
- ☐ Numbness
- ☐ Weakness

Since the problem started, is it:

- ☐ About the same
- ☐ Getting better
- ☐ Getting worse

What makes your pain worse?

- ☐ Sitting
- ☐ Standing up from a chair
- ☐ Walking

Does your pain interfere with: Sleep Hobbies Leisure Work Yes / No

What type of work do you do?

Have you had any x-rays, ultrasounds, MRI's or CT's relating to this issue? Yes / No
(If yes, what and where?)

List any medications you are taking:

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Have you ever taken oral cortisone or prednisone *(including asthma medications such as14 Pulmicort, Symbicort, Flixotide & Seretide)?* Yes / No *If yes, please specify what:*
Are you pregnant? Yes / No / NA If Yes, how many weeks?

Do you have or have you ever had? *(please tick)*		
☐ High blood pressure	☐ Cancer	☐ Spinal fracture
☐ Heart attack	☐ Osteoporosis	☐ Spinal surgery
☐ Heart problems	☐ Rheumatoid arthritis	☐ Dislocations
☐ Strokes	☐ Ankylosing spondylitis	☐ Ligament injuries
☐ Diabetes	☐ Psoriatic arthritis	☐ Cartilage injuries
☐ A pacemaker	☐ Reiter's arthritis	☐ Osteoarthritis
☐ An aneurysm	☐ Spinal trauma	☐ Dizziness

Have you seen another exercise physiologist before? Yes / No
18. Other health professionals seen for this problem (please list) ☐ Medical doctor: ☐ Specialist doctor: ☐ Chiropractor: ☐ Physiotherapist: ☐ Other:
19. Was there anything you were not happy about with your prior treatment?
20. What aspect were you happy with?

ADULT PRE-EXERCISE SCREENING SYSTEM (APSS)

Has your medical practitioner ever told you that you have a heart condition, or have you ever suffered from a stroke?	Yes / No
Do you ever experience unexplained pain or discomfort in your chest at rest or during physical activity/exercise?	
Do you ever feel faint, dizzy or lose balance during physical activity/exercise?	Yes / No
Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	Yes / No
If you have diabetes *(type 1 / 2)* have you had trouble controlling your blood sugar (glucose) in the last 3 months?	Yes / No
Do you have any other conditions that may require special consideration for you to exercise? *If yes, please list*	Yes / No

Describe your current physical activity/exercise levels in a typical week by starting the frequency and duration at the different intensities.

Intensity: Light Moderate Vigorous

Frequency: _____ _____ _____ Weighted Physical Activity (Sessions/week)

Duration: _____ _____ _____ TOTAL = _____ minutes / week (total minutes/week)

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Participant Exercise Physiology Office Policy

Iconic Care Pty Ltd is committed to improving health and well-being through personalized, evidence-based Exercise Physiology services. Our mission is to empower individuals of all abilities with tailored exercise programs that enhance mobility, strength, and overall quality of life.

PRIVACY POLICY STATEMENT: In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between practitioners within this clinic. Also, when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Mobile Phones: Out of respect for others, please turn off your mobile phone.

Recovery: Keep in mind that not everyone recovers or heals at the same pace, and that both processes need time. We would ask you to speak with your exercise therapist if, at any point during your therapy, you feel that you are not reacting as well as you should. At Iconic Care PTY LTD, we want you to benefit as much as possible from your treatment.

Fees / Your Account: Fees for private patients are due at the time of service. EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workcover and DVA patient accounts will be sent directly to the appropriate body.

NDIS participants that are NDA / Plan managed will have invoices raised to the managers selected to allocate their funds – Private / Self-managed participants will have their invoices raised to either themselves or carer/guardian in charge of funding.

Appointment Scheduling: Your Exercise therapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance or make appointments set to repeat for the duration of your action plan.

Missed Appointments: Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If an appointment must be changed, 24 hours' notice is appreciated. If less than 24 hours' notice is given for a cancellation, a cancellation fee may be charged. Consideration will be given for unavoidable circumstances. This fee is not covered by compensable bodies and must be paid by the patient. People who repeatedly miss or reschedule appointments will regretfully be advised to from care as we realise you will not reach your health goals, and we do not wish to waste your time.

I, _____ have read and understood the above office policy form. I agree to these conditions for the psychological service provided to me by the Exercise therapist.

Signature: _____ Date: _____