H.O.P.E.

Helping Open Possibilities with Exercise

March 1st, 2017

Scheduling and Billing Policies

HOURS REMINDER

Break the Barriers' office is open Monday – Thursday 8:45am to 7pm; Friday 8:45am-6pm; Saturday 8:45am-12:30pm

HOPE program hours are Monday through Friday 9am – 5:30pm

SCHEDULE CHANGES

All schedule changes are handled through the Front Office. It is your responsibility to fill out a "***HOPE Schedule Change Request***" form at the front desk. A Trainer will contact you if clarification is necessary.

Constant schedule changes are disruptive to the entire schedule. We will attempt to accommodate your request, however, please understand that we reserve the right to offer that time slot to another client on a permanent basis. We will make every effort to find you another suitable time slot. Total payment amount is due before the 1st of the month.

CANCELLATIONS AND NO-SHOWS

All clients must cancel by 5pm, the day before they are scheduled, in order to reschedule a session. Any cancellations without this notice (regardless of the reason) will be charged against your account for the total hours cancelled for that day and the session will not be rescheduled. When you cancel, your time slot may be filled by another client.

TARDINESS

Out of respect for your trainer's time, please be ready to start 5min before your session begins. If you will be delayed more than 10 minutes for any reason, you are required to contact the office *BEFORE* your scheduled time in order to attend the remaining balance of your session. Failure to notify the office in advance will constitute a "No-Show" and your missed session will fall under the normal cancellation policy. Any delays greater than half of your scheduled session (with or without notifying the trainer) will fall under the normal cancellation policy.

PAYMENT DEADLINES & LATE FEES

Payment is due on the last day of the preceding month for the following month's sessions. E.g., hours scheduled for January are due for payment on December 31st. Payment reminders are given out one week before the next month's sessions. E.g., February's reminder will be sent out the last week in January. If you do not receive a reminder and you are scheduled for the following month, please contact the front office at (559) 432-6292.

Payments received on or after the 1st of each month will be considered late and will incur a late fee of $10. Late fee payments will be due with your full payment. If you intend on bringing payment to your next appointment that is on or after the 1st, it will be considered late, so please mail it in ahead of time, or contact the office and pay via credit card over the phone.

Delinquent payment by the 5th of each month will result in removal from the schedule until the account is current. At this point, your time slot will be released and may be filled by someone else.

FRONT DESK PHONE NUMBER
If you have any questions or comments about these policies or anything else, please leave a message with the front desk at (559) 432-6292.

Note: The HOPE program reserves the right to change its scheduling and billing policies at any time with or without notice.

I, _____, the undersigned, do hereby acknowledge receipt of the Scheduling and Billing Policies, have read its' entirety and agree to follow and be subject to the terms outlined above.

Printed Name: _____ Date: _____
of Adult Client or Guardian of Minor

Phone Number (required for setting up schedule): (_____) _____--_____

Signature: _____ Date: _____
of Adult Client or Guardian of Minor

--Must Select One--

Reason for Interest in ***H.O.P.E.***

(**Requires** HOPE Dr. Release):

__ Spinal Cord Injury
__ Cerebral Palsy
__ Spina Bifida
__ Stroke
__ Traumatic Brain Injury
__ Multiple Sclerosis
__ Neuropathy
__ Parkinson's disease
__ Unknown Neurological Condition

Reason for Interest in ***Personal Training***

(**Doesn't** Require HOPE Dr. Release):

__ Fitness
__ Weak or injured shoulder/back/legs
__ Pain in shoulder/back/legs
__ Other

Galileo Release Form

I, _____ , certify that the following is a true and correct account of the conditions that may limit my use of the Galileo machines. Failure to correctly disclose any of these contraindications may result in my removal from the HOPE program.

Contraindications:

- Currently Pregnant (or trying): ( ) Yes ( ) No
- Acute Thrombosis (acute vascular constriction): ( ) Yes ( ) No
- Artificial Joints (or other joint/bone implants): ( ) Yes ( ) No

If Yes, please list all areas of the body where these joints/implants are located:

_____

_____

- Active arthrosis or arthropathy (acute inflammation of the locomotor system; i.e. acute inflammation or swelling of joints): ( ) Yes ( ) No

If Yes, please list all areas of the body where this inflammation is located:

_____

_____

- Acute tendinopathy (acute tendon inflammation): ( ) Yes ( ) No

If Yes, please list all areas of the body where this inflammation is located:

_____

_____

- Acute hernia (soft tissue prolapse): ( ) Yes ( ) No

If Yes, please list all areas of the body where these hernias are located:

_____

_____

- Acute discopathy (acute problems at the intervertebral disc):( )Yes ( )No

If Yes, please list all areas of the spine where these problems are located:

_____

_____

- Fresh fractures: ( ) Yes ( ) No

If Yes, please list all areas of the body where these fractures are located:

_____

_____

- Gallstones or stones in the urinary tract system: ( ) Yes ( ) No

Rheumatoid Arthritis: ( ) Yes ( ) No *If Yes, please list all areas of the body where the arthritis is located:*

_____

_____

- Epilepsy: ( ) Yes ( ) No

I, _____ , know I am responsible to keep my trainer informed of any changes in my health, especially regarding this list. Failure to keep my trainer informed of all health changes may result in my removal from the HOPE program. I understand that some of these contraindications are temporary, and may result in a temporary cessation of Galileo use.

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Signature of Client's Parent or Guardian (if under 18):

_____ Date: _____

Doctor's & Specialist's Release for Participation in the HOPE Program

HOPE is the acronym for "Helping Open Possibilities with Exercise". This program benefits individuals who have had a spinal cord or other neurological injury; including those with cerebral palsy, spina bifida, stroke, traumatic brain injuries and other physical needs. Our trainers use intense exercise, full-weight load bearing, and repetitive stimulation to improve mobility, strength and range of motion in participants. It is NOT considered physical therapy. *By signing below, the Doctor& Specialist give consent for the "Participant" to participate in the HOPE program*.

Participant's Name: _____ DOB_____/_____/_____

Unless marked here, signing below indicates a Bone Density Test is *NOT requested* by the Primary Care Doctor or the Specialist.

(A Bone Density Test is always REQUIRED for all Spinal Cord Injury clients who have been injured for longer than one year)

☐ **Yes, the Participant is requested by the Physician to have a Bone Density Test prior to joining the HOPE program**

Please mark all health conditions

☐ Paralysis (SCI) Level: _____
- Date of Bone Density Test: ____/_____/_____
- Please attach Copy of BD Test

☐ Autonomic Dysreflexia (AD)
☐ Epilepsy ☐ Fainting Spells
☐ Cerebral Palsy ☐ Spina Bifida
☐ Tourette's Syndrome ☐ Autism
☐ Severe Allergy ☐ Hepatitis
☐ Down's Syndrome - Release on file: ( ) Yes ( ) No
☐ Atlantoaxial Instability X-Ray: ( ) Yes ( ) No
☐ Recent Contagious Disease: _____
☐ Serious Accident Date: _____
☐ Serious Illness Date: _____

☐ Bleeding Issues ☐ Diabetes
☐ Asthma/RAD ☐ Kidney Problems
☐ Head Injury ☐ Hearing Difficulty
☐ Tuberculosis ☐ Vision Difficulty
☐ Disability/Diagnosis other than listed:

_____

*****Requires a Specialist's Signature*****

☐ Shunt ☐ Bone/Joint Problems
☐ Heart Condition **(Type):** _____
☐ Recent Surgery **(Date):** _____
☐ Posttraumatic Stress Disorder (PTSD)
☐ Traumatic Brain Injury

Please list any instructions or concerns regarding pertinent health conditions (use back side if necessary):

_____

Print Primary Doctors Name: _____ Primary Doctor's Address: _____ Phone: _____ Fax: _____ Primary Doctor's Signature: _____ Date Completed: _____/_____/_____	***Print ***SPECIALIST's*** Name: _____ Specialist's Address: _____ Phone: _____ Fax: _____ Specialist's Signature: _____ Date Completed: _____/_____/_____

The HOPE program exists to provide an improved quality of life for people with spinal cord injuries through intense exercise-based recovery programs, education, support and encouragement.

Doctor's/Specialist's Bone Density Test Interpretation:

(Only required upon Physician's written request –OR– if Client experienced a Spinal Cord Injury, at least a year ago, which has resulted in paralysis):

Patient Name: _____

Bone Density Test Date: _____

Interpretation of Bone Density Results (i.e. Patient has normal bone density and can endure full-load bearing for long periods of time): _____

_____

_____

_____

_____

_____

Restrictions (if applicable):_____

_____

_____

_____

_____

_____

The **attached** Bone Density Test results have been interpreted by the following medically trained professional:

Printed Name: _____

Signature: _____

Date: _____

Bone Density Test is attached: □ Yes