



H.O.P.E.

Helping Open Possibilities with
Exercise

Veteran Form

November 1, 2015

Scheduling and Billing Policies

HOURS REMINDER

Break the Barriers' office is open Monday – Thursday 8:30am to 7:00pm; Friday 8:30am-6pm;

Saturday 8:30am-1:00pm

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

SCHEDULE CHANGES

All schedule changes are handled through the Director. It is your responsibility to notify the front desk; please do not give any changes to the Trainers. The Director is in charge of appointment scheduling so only notification through the Director will be recognized as a requested schedule change.

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.

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. Please remember to respect the use of this GRANT MONEY so that it can be used as effectively as possible. Continual no-shows and last-minute cancellations will result in your removal from this Grant opportunity.

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 & SCHEDULING

Please remember that your sessions are being paid for because of the tireless efforts of our Grant Writing Team. We want to use these funds as responsibly as possible, for the benefit of our Veteran program and participants. With these grants, each Veteran is allowed two (2), 1-hr sessions each week. Special consideration may be made (on a case by case basis) for clients who may require additional time due to the severity of their injury. This consideration is up to the sole discretion of our CEO. For all Veterans, additional weekly sessions may be purchased at the public rate, as outlined below*.

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.

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***PRE-PAYMENT**

Payment is due on the last day of the 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 hours. 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, you are still responsible for timely payment.

Sessions are \$45.00 per hour. Payments received on or after the 1st of each month will be considered late and will incur a late fee of \$5. 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 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 account is current. At this point, your time slot will be released and may be filled by someone else.

**in the case of a No-Show, cancellation payment will be taken from public payments before Grant payments*

FRONT DESK PHONE NUMBER

If you have any questions or comments about these policies or anything else, please call the front desk at (559) 432-6292.

Note: The HOPE program reserves the right to change or revoke 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: _____

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

Signature: _____ Date: _____

--Must Select One --

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

Reason for Interest in **Personal Training**

(Requires H.O.P.E. Dr. Release):

(Doesn’t Require H.O.P.E. Dr. Release):

- Spinal Cord Injury
- Stroke
- Traumatic Brain Injury
- Multiple Sclerosis
- Neuropathy
- Parkinson’s disease
- Unknown Neurological Condition

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

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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

<input type="checkbox"/> Paralysis (SCI) Level: _____ <ul style="list-style-type: none"> • Date of Bone Density Test: ____/____/____ • Please attach Copy of BD Test <input type="checkbox"/> Autonomic Dysreflexia (AD) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Tourette's Syndrome <input type="checkbox"/> Autism <input type="checkbox"/> Severe Allergy <input type="checkbox"/> Hepatitis <input type="checkbox"/> Down's Syndrome - Release on file: () Yes () No <input type="checkbox"/> Atlantoaxial Instability X-Ray: () Yes () No <input type="checkbox"/> Recent Contagious Disease: _____ <input type="checkbox"/> Serious Accident Date: _____ <input type="checkbox"/> Serious Illness Date: _____	<input type="checkbox"/> Bleeding Issues <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma/RAD <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Vision Difficulty <input type="checkbox"/> Disability/Diagnosis other than listed: _____ <hr/> <p style="text-align: center;">***Requires a Specialist's Signature***</p> <input type="checkbox"/> Shunt <input type="checkbox"/> Bone/Joint Problems <input type="checkbox"/> Heart Condition (Type): _____ <input type="checkbox"/> Recent Surgery (Date): _____ <input type="checkbox"/> Posttraumatic Stress Disorder (PTSD) <input type="checkbox"/> Traumatic Brain Injury
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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: ____/____/____
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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