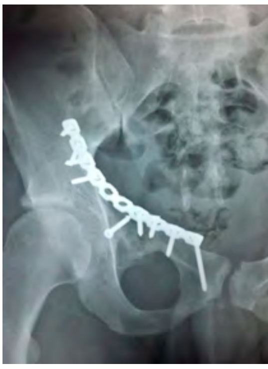


PATIENT INFORMATION FORM

CHRIS ANASTASIOS AEP

ESSA Accredited Exercise Physiologist
Medicare Provider No.: 4739732L
ABN: 64 165 634 037
Address: 94 Glenelg Avenue
Wembley Downs 6019
Phone: 0438 801 244
Email: chris@caexphys.com

The purpose of this consent form is to inform you, prior to treatment, that if you decide to commence with the treatment, the cost of the treatment must be paid in full after each session. The patient will be responsible for claiming their rebate by Medicare or their private Health Fund.

Patient details:

Mr Mrs Miss Ms Other

Surname: First name: Middle initial:

DOB: Email:

Address: Post code:

Postal address (leave blank if same as above):

Home Phone: Mobile:

Regular General Practitioner Details:

Name: Health Clinic:

Health Insurance Details:

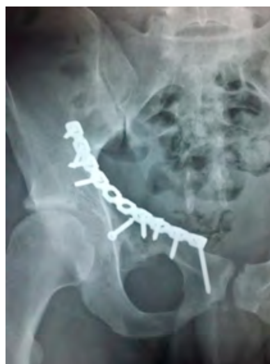
Health Fund: Membership No:

Person Responsible for the account:

Name: Relationship:

Address: Postcode:

Comments or Restrictions:



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Consent (Guardian consent required for minors)

Exercise training programs are designed to improve Cardiovascular (heart and lungs) Fitness, Muscle Tone and Strength, Endurance and Flexibility and may include physical activities such as Running, Stretching, Lifting Weights and using Gym Equipment/Machines. Each part of the program and each exercise will be fully explained to you, PLEASE ask questions if you are not clear about anything. PLEASE also notify the trainer/physiologist if you feel you should not do a particular exercise for ANY reason.

Important Information:

Any exercise program contains certain risks such as Muscle pulls, Joint strains, Aches, Pains and general discomfort. Your program will be designed to minimise these risks and you are advised to start slowly and increase your level of activity gradually. However, if at any time during an exercise session you feel pain or discomfort, please inform the trainer/physiologist immediately.

Cancellation Policy

All cancellations must be received at least 24 hours before your consultation in order to avoid being charged. Clients who do not cancel with 24 hours notice will be charged a fee corresponding to 50% of the rate for the cancelled consultation.

I, (the undersigned) ____,

of ____,

hereby state that that I have read, understood and answered all the questions truthfully. Any queries have been answered to my satisfaction. I also state that I wish to participate in the range of activities including cardiovascular and resistance (weight bearing) exercise. I realise that these activities involve the risk of injury or even death.

Signed: ____

Witnessed: ____

Date: ____________