100 Bauer Drive, Oakland, NJ 07436
Phone: 201-644-7567
Fax: 201-644-7568

Client Application

Date_____
mm/dd/yyyy

Name_____
Last *First* *Middle (complete)*

Prefer to be called (nickname)_____ Gender □ M □ F
□Prefer not to answer

Birthdate_____/_____/_____ E-mail Address_____
mm/dd/yyyy

Permanent Home Address_____
Number and Street

_____

_____
City or Town *State* *Country* *Zip Code*

Permanent home phone (_____)_____
Area Code *Number*

Other phone (___)_____
Area Code *Number*

Emergency contact

Name_____ Relationship_____
Last *First*

Home phone (_____)_____ Work/Cell phone (_____)_____
Area code *Number* *Area code* *Number*

How did you hear about Push to Walk?_____
_____
_____

Medical Information

Date of Injury _____/_____/_____ Type of injury_____
mm/dd/yyyy

Cause of Injury or Diagnosis _____

At what hospital were you treated?

_____
Name

_____
Address

_____

City *State* *Zip Code*

Treating physician

_____

(_____)_____
Area Code *Number*

Length of stay

from_____/_____/_____
mm/dd/yyyy

to _____/_____/_____
mm/dd/yyyy

Location of inpatient rehabilitation:

_____
Name

_____
Address

_____
City *State* *Zip Code*

(_____)_____
Area Code *Number*

Length of stay
from_____/_____/_____
mm/dd/yyyy
to _____/_____/_____
mm/dd/yyyy

Location of outpatient rehabilitation:

_____
Name

_____
Address

_____
City *State* *Zip Code*

(_____)_____
Area Code *Number*

Dates of Attendance
from_____/_____/_____
mm/dd/yyyy
to_____/_____/_____
mm/dd/yyyy

Type of wheelchair □Manual □Electric_____ □Power Assisted/Manual
specify

Assistive standing/walking device
□Yes _____ □No

Communication: Verbal or Nonverbal
If nonverbal, describe methods of effective communication used (i.e. written, diagrams, sign language)

_____
_____
_____

Comprehension: Full / Partial / Minimal

_____
_____
_____
_____

Current therapy □ Yes □ No

Type_____ Frequency_____
_____ _____
_____ _____

Results_____
_____

Surgeries since injury

Date	*Type*	*Location*
Date	*Type*	*Location*
Date	*Type*	*Location*

Date of last medical examination _____/_____/_____
mm/dd/yyyy

Height_____
Weight_____

Please list all current medications

1			
Name	*Dose/Freq*	*Function*	*Start mo/yr*
2			
Name	*Dose/Freq*	*Function*	*Start mo/yr*
3			
Name	*Dose/Freq*	*Function*	*Start mo/yr*
4			
Name	*Dose/Freq*	*Function*	*Start mo/yr*
5			
Name	*Dose/Freq*	*Function*	*Start mo/yr*
6			
Name	*Dose/Freq*	*Function*	*Start mo/yr*

Allergies

_____
_____

Describe your physical abilities (be as specific as possible):

Upper extremities

_____
_____
_____

Trunk/core (IE: Can you sit up?)

_____
_____
_____

Lower extremities

_____
_____
_____

Balance Function

_____
_____
_____

Any spasms? □ Yes □ No

If Yes, briefly explain cause(s) & location(s)

_____
_____
_____

Any pain? □ Yes □ No

If Yes, briefly explain cause(s) & location(s)

_____
_____
_____

On a scale from 1-10, with 1 being mild and 10 being unbearable, how would you rate your pain?
1 2 3 4 5 6 7 8 9 10

Seizures? □ Yes □ No

If Yes, briefly explain cause(s), frequency, & treatment

_____
_____
_____

Any Autonomic Storming? □ Yes □ No

If Yes, briefly explain symptoms

_____
_____
_____

Any Pressure Sores/Skin Breakdowns? □ Yes □ No

If Yes, briefly explain symptoms & location(s)

_____
_____
_____

Any Heterotrophic Ossification? □ Yes □ No

Location

_____

_____

Have you been diagnosed with Osteoporosis? □ Yes □ No

How long ago was your last bone scan?

_____

NOTE: Please attach a recent bone density scan with your doctor's interpretation.

Deep Vein Thrombosis? □ Never □ Past □ Present

Location_____
Treatment_____

Ventilator Dependent? □ Never □ Past □ Present

Major illness/injuries/complications that required hospitalization other than initial injury/diagnosis?
□ Yes □ No

If Yes, explain:

_____

_____

_____

What are your goals and / or health concerns for coming to Push to Walk?

_____

_____

_____

Please circle 'yes' or 'no' for the following. Please answer 'yes' to those that apply to you at present or have applied to you in the past, with a brief explanation in the space provided.

Heart problems: yes / no

_____

History of chest pain: yes / no

_____

Blood pressure issues: yes / no

_____

Diabetes: yes / no

_____

Any chronic illness or condition: yes / no

_____

Fatigue: yes / no

_____

Muscle tension: yes / no

_____

Tendon/joint problems: yes / no

_____

Breathing/lung problems: yes / no

_____

High cholesterol: yes / no

Cigarette smoker: yes / no *if yes, packs per day*

Alcohol: yes / no *if yes, frequency*

History of depression: yes / no *if yes, details of management*

Are you accustomed to physical exertion?

Hernia, or any condition that may be aggravated by intense exercise: yes / no

Any other disease or disorder that would cause difficulties while participating in an intensive exercise program?

Are you currently involved in any recreational physical activities (IE: handcycling, rugby, etc)?

Has your physician approved your participation in an intense exercise program? yes / no
NOTE: This is required prior to your first session at Push to Walk.
Is there any reason not mentioned here why you should not follow a regular exercise program? If yes, please explain: _____

Please make any other comments you feel are pertinent to your exercise program:

I have completed this application to the best of my knowledge. I understand that if necessary, Push to Walk reserves the right to request medical clearance before beginning any exercise program, and has the right to deny my participation in the program if requests are not fulfilled.

Please print your name clearly:_____

Signature:_____ **Date:**_____

If under 18, name of parent or guardian:_____ **Relationship:**_____

Parent or guardian's signature:_____ **Date:**_____

Thank you for taking the time to fill out Push to Walk's application.

QUALIFICATION QUESTIONNAIRE		
APPLICANT INFORMATION		
Name:		
Height:	Weight:	
Date of birth:	Age:	Home Phone:
Current address:		
City:	State:	Zip Code:
Cell Phone:	E-Mail:	
PREFERRED METHOD OF CONTACT		
INJURY/DIAGNOSIS INFORMATION		
Date of Injury/Diagnosis:		
Details of Injury/Diagnosis:		
Symptoms of Injury/Diagnosis:		
State Goals and Objectives in Attending Push to Walk:		
HOW DID YOU HEAR ABOUT PUSH TO WALK?		
PRIOR TREATMENTS		
Dates	Facility	Type of Treatment
SIGNATURES		
I certify that all information provided above is truthful and accurate. I certify that I am physically capable of participating in an intensive exercise program and that I have no other medical complications. I certify that I have the ability to breathe on my own and do not use a ventilator. A doctor's letter and a bone density scan will be required prior to an initial evaluation and start of a regular program. I also certify that I personally have the funds to pay for Push to Walk's services which will be billed monthly and paid in advance of treatment. Current fee is $98/hour.		
Signature of applicant:		Date:
Signature of guardian (if under 18 years old):		Date:

Physician's Clearance Form

Please return this form to:
Push to Walk, 100 Bauer Drive, Oakland, NJ 07436
Phone: 201-644-7567; Fax: 201-644-7568

Date _____
Patient's Name _____ Age _____
Patient's Address _____
Date of last physical examination _____

_____ This patient may participate fully in an intensive physical exercise program consisting of cardiovascular, strength, flexibility and load bearing training of both the upper and lower extremities without limitation.

_____ This patient may participate in an intensive physical exercise program with the following limitations and/or recommendations:

_____
_____
Please include a brief description of any medical condition(s) that may affect her/his participation in an intensive exercise program:

_____
_____

If this patient is on any medication that may affect the heart rate or the blood pressure to response to exercise (elevating or suppressing), please indicate:
I consider the above individual to be: _____ normal
_____ cardiac patient
_____ coronary heart disease
_____ other (explain)

Please fill in the following information if available:
Blood Pressure _____
Glucose _____
Total serum cholesterol _____
HDL-C _____ LDL-C _____
Triglycerides _____

Physician's Name _____ Date _____
Physician's Signature _____

*Note – this record must be stamped with a physician's official stamp or be accompanied by a typed letter on physician's letterhead, documenting that a medical evaluation has been performed on named client. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.

Required – Bone Density Test & Results

Before we can see any new client, he or she must have a bone density test (also called a Densitometry or DEXA scan) performed and have the results sent or faxed to us. This is very important, so we know if there is increased risk of fracture due to osteopenia or osteoporosis. It's also important that you know this, too, for your general health and well-being.

Please be sure that it includes testing and T scores of the following:

- **Lumbar spine**
- **Right and Left Hips**
- **Greater Trochanter**
- **Distal Femur**

If you have had a bone test performed in the last 6 months, you don't need to have another one done, but you do need to send or fax us the results.

Follow-up requirements for subsequent testing will be determined by these initial test results.

We need to have this report prior to scheduling your evaluation appointment.

Thank you.

www.pushtowalknj.org
100 Bauer Drive, Oakland, NJ 07436
Phone: 201-644-7567; Fax: 201-644-7568
E-mail: kwolfe@pushtowalknj.org

Waiver & Release from Liability

I, _____, ("Client") HEREBY WAIVE AND RELEASE, indemnify, hold harmless and forever discharge Push to Walk ("the Company") and its agents, employees, directors, affiliates, successors and assigns, of and from any all claims, demands, contracts, expenses, causes of action, lawsuits, damages, and liabilities of every kind of nature, whether known or unknown, in law or equity, that Client has had or may have, arising from or in any way related to Client's participation in any of the events of activities conducted by or on the premises of or for the benefit of the Company.

I represent that I am in satisfactory physical condition to participate in the Company's program and activities. I authorize any person connected with Push to Walk to administer first aid to me, as they deem necessary. I authorize medical and surgical care and transportation to a medical facility or hospital for treatment necessary for my well-being, at my expense.

Client acknowledges that any activities Client participates in can be an extreme test of Client's physical and mental limits and carry the potential for severe physical injury. Client hereby assumes the risks of participating in any and all of the Company's activities and functions. Client certifies that Client is able to participate in the Company's programs and has not been advised otherwise by a qualified medical professional. Client understands that the information and treatments obtained by participating in the Company's events and activities do not constitute medical treatment, diagnosis or advice. Client understands that Client should seek the advice of a physician or other qualified health provider if Client has questions about medical condition(s). Client understands that a bone density scan is required prior to participating in Company's programs, and that the bone density scan results will be shared with the Company.

Client certifies that in consideration of becoming a client of the Company's program, Client hereby takes the following action for itself, its executors, administrators, heirs, next of kin, successors and assigns:

Client waives, releases and discharges from any and all claims or liability for any loss, damage, theft or injury of any kind which arise out of or are related to Client's participation in, or its traveling to and from the Company's facilities; including but not limited to: 1) any known and unknown, foreseen and unforeseen body and personal injury, 2) loss of life, and 3) any attorney's fees, costs, expenses, or charges sustained, directly or indirectly, or alleged to have been sustained, or in any fashion, arising from, in connection with, or resulting from its participation in the Company's programs or activities, even if due to the negligence of the Company or any employee, volunteer, director, officer, client, owner or agent thereof.

Client will indemnify and hold harmless the Company and any and all employees, volunteers, directors, officers, clients, owners and agents thereof from any claim, demand, and/or cause of action of any nature whatsoever, related to the Client's participation in the Company's programs and activities, even if due to the negligence of the Company, including but not limited to any and

all losses, liabilities, damages, costs and expenses (including reasonable attorney fees) arising out of such actions.

Client agrees that Client, Client's family members, and any guests and invitees shall be bound by this agreement and the Company's policies, rules and guidelines. Client agrees that the Company's policies, rules and guidelines may be revised, supplemented, or amended in the sole and absolute discretion of the Company, and that any changes shall become immediately effective upon posting in the Company's facilities.

Client further expressly agrees that the foregoing waiver and release from liability agreement is intended to be as broad and inclusive as permitted by the law of the State of New Jersey. Client has read this waiver and release from liability and indemnity clause, and agrees that no oral representations, statements or inducements apart from this agreement have been made. The Company makes no warranties or representation, express or implied, other than those set forth herein. IN NO EVENT SHALL THE COMPANY BE LIABLE FOR ANY SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES.

This agreement shall be construed in accordance with the laws of the State of New Jersey, without regard to the conflicts of law provisions thereof. Any controversy, claim or dispute arising out of or relating to this agreement shall be settled by a retired Judge of the Superior Court of the State of New Jersey chosen by the Company. The parties agree to abide by all decisions and awards rendered in such proceedings. Such decisions and awards rendered by the Arbitrator shall be final and conclusive and may be entered in any court having jurisdiction thereof as a basis for judgment and of the issuance of execution for its collections. All such controversies, claims or disputes shall be settled in this manner in lieu of any action at law of equity, provided however, that nothing in this subsection shall be construed as precluding bringing an action for injunctive relief or other equitable relief. The arbitrator shall not have the right to award punitive damage or speculative damages to either party and shall not have the power to amend this agreement. IF FOR ANY REASON THIS ABRITRATION CLAUSE BECOMES NOT APPLICABLE, THEN EACH PARTY, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY AS TO ANY ISSUE RELATING HERETO IN ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT OR ANY OTHER MATTER INVOLVING THE PARTEIS HERETO.
I HAVE READ THE PREVIOUS PARAGRAPHS AND I KNOW, UNDERSTAND AND APPRECIATE THESE AND OTHER RISKS THAT ARE INHERENT IN THE PUSH TO WALK PROGRAM. I HEREBY ASSERT THAT MY PARTICPATION IS VOLUNTARY AND THAT I KNOWINGLY ASSUME ALL SUCH RISKS AND ENTER INTO THIS WAIVER AND RELEASE FROM LIABILITY VOLUNTARILY. I FURTHER UNDERSTAND AND AGREE THAT THIS AGREEMENT SHALL ALSO BE BINDING ON MY HEIRS, ASSIGNS, SUCCESSORS AND ALL OTHER PERSONS WHO MAY CLAIM THROUGH ME.

All notices to the Company shall be mailed (certified or registered, return receipt requested) to Push to Walk, 100 Bauer Drive, Oakland, NJ 07436. If any part of this agreement is held by a

court of competent jurisdiction to be void and unenforceable, the remainder of the terms and provisions of this agreement shall remain in full force and effect and shall not be affected.

Client Name _____

Client Signature _____

Date _____

www.pushtowalknj.org
100 Bauer Drive, Oakland, NJ 07436
Phone: 201-644-7567; Fax: 201-644-7568
E-mail: kwolfe@pushtowalknj.org

Payment Policies

Updated 12/12/17

Hourly fee:
One-on-One Workouts-$98.00;
FES RT600 Sessions-$98.00;
FES RT200 & RT300 Add-on Sessions-no charge; Stand-alone session-$50.00
Add-on Sessions are only offered with workouts*; *FES pads are an additional charge

For local clients who will be coming on a weekly basis, the initial two hour evaluation is offered at no charge. For clients visiting from out of town for a limited amount of time, all hours with the trainer are billed on an hourly basis. However, we will schedule an additional half an hour prior to the first visit to discuss medical history and goals and another half an hour after the final session to review visit and answer any questions. This is to ensure maximum training time for the duration of the visit.

All clients will be billed at the end of the month. Payments must be made by cash or check. Sessions and hours will be billed based on actual attendance. Clients must inform Push to Walk prior to the first of the month if a known appointment time cannot be kept for scheduling purposes.

Every client will be required to provide a valid credit card and keep it updated to pay any invoice that is past 30 days due, plus a $50 late fee and a 3% handling charge. **Credit cards will ONLY be billed in these cases, and will not be taken for regular, on-time payments.**

Any session cancelled with less than 24 hours notice (including weekends for Monday appointments) WILL BE BILLED at $98.00 per hour, with the exception of medical emergencies. Calls to cancel MUST be made to the office phone number (201-644-7567). If no one answers, you must leave a message. E-mails, text messages and calls to trainers' cell phones are not acceptable and are not valid for cancellation purposes, unless a true emergency exists.

Exception – if Push to Walk is closed due to bad weather, or if the roads are unsafe for travel, clients will not be billed for sessions missed.

Invoices are prepared on the last day of the month. Payment is due by the 10th of the month following the sessions. Any payment received after the 10th is subject to late fee of $50.00.

If payment plus late fee is not received by the 15th, client will be removed from the schedule until full amount of invoice plus late fee is received.

If payment is not received within 30 days, the credit card provided WILL be charged $50 late fee plus a 3% handling fee.

Visiting clients are required to pay for their estimated number of hours plus Home Program, Train Your Trainer and Home Manual costs 2 weeks in advance of their visit. Any variations in scheduling or hours will be due and payable on the final day of the visit.

Client Name _____ Client Signature _____ Date _____

www.pushtowalknj.org 100 Bauer Drive, Oakland, NJ 07436
Phone: 201-644-7567; Fax: 201-644-7568; E-mail: kwolfe@pushtowalknj.org

Credit Card Agreement & Information for Clients

This agreement is between Push to Walk and _____
(Name of client – please print)

The following credit card information is provided and will be used ONLY if payment is not made within 30 days of billing. A $50 late charge plus a 3% handling charge will be added to any amount due.

Name on Card:_____

Billing Street Address: _____

City: _____ State:_____ Zip:_____

Type of Card:_____ Credit Card #:_____

Expiration Date:_____ Security Code:_____

Client Signature _____ Date: _____

Credit Card Holder Signature _____ Date: _____

For those clients covered by Worker's Comp Coverage

Push to Walk will prepare and send monthly invoices to the designated insurance company handling the above client's Worker's Comp case and will accept payment from the insurance company.

However, the responsibility of payment for services ultimately lies with the client. If, for whatever reason, the insurance company does not pay, the client accepts complete responsibility for making payment in full within 10 days of notification that a balance is due.

Further, according to Push to Walk's Payment Policies, any payment received after the 10 days is subject to a late fee of $50. If payment plus late fee is not received within 15 days, client will be removed from the schedule until full amount due plus late fee is received.

By signing this Agreement, client acknowledges understanding of this policy and agrees to its terms.

Signature_____ Date _____