Chan Soon-Shiong Medical Center at Windber

NEW MEMBERSHIP APPLICATION & AGREEMENT – DAVIDSVILLE

Applicant Name: _____
(Last) (First)

Home Address: _____

City/State/Zip: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Employer: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Emergency Phone: _____ Relationship: _____

Health Insurance: _____ ID Number: _____

Primary Care Physician: _____ Physician Phone: _____ Date of Last Physical: _____

Acceptance and approval by Davidsville HealthStyles constitutes a contract between the parties granting the Applicant all rights and privileges afforded a member under the current Terms and Conditions of Membership, Rules, Regulations and Policies which may be amended at the anniversary date. The undersigned states that he/she has read and understands the Terms and Conditions of Membership and the Membership Agreement, and agrees to be bound by such Terms and Conditions.

NOTICE TO THE APPLICANT

By signing this Application and Agreement you agree that (1) to the best of your knowledge, everything you state on this application is accurate; (2) Davidsville HealthStyles may retain this application form whether or not it is approved; (3) Portage HealthStyles is authorized to check your references and your credit and employment history, to verify any information you have provided in this application, and to answer any inquiries about the facilities credit experience with you.

Signature confirms that you understand and agree to the above and the enclosed Terms and Conditions of Membership and the Rules, Regulations and Policies.

Applicant's Signature: _____ Date: _____

NEW MEMBER HEALTH QUESTIONNAIRE

Check all that apply: ☐ Smoking ☐ Stroke ☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes ☐ Obesity ☐ Family History Heart ☐ Sedentary /Inactive

How would you rate your present level of fitness? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Do you take any medications prescribed by your physician? ☐ Yes ☐ No

If yes, please specify: _____

Are you currently being treated for any heart problems? ☐ Yes ☐ No

If yes, please explain: _____

Do you have a past history of heart problems? ☐ Yes ☐ No

☐ Heart Attack ☐ By-Pass Surgery ☐ Valve Replacement

☐ Pacemaker ☐ Angioplasty ☐ Stent Placement

Have you ever had a stress test? ☐ Yes ☐ No When: _____

Have you ever had a cardiac catheterization? ☐ Yes ☐ No When: _____

Are you currently involved in a physical or occupational therapy program? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any surgeries in the past 6 months? ☐ Yes ☐ No

If yes, please explain. _____

Physical Activity Readiness Questionnaire

Yes	No	
☐	☐	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
☐	☐	2. Do you feel pain in your chest when you do physical activity?
☐	☐	3. In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
☐	☐	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
☐	☐	7. Do you know of any other reason why you should not do physical activity?

If yes, please explain: _____

I have read, understood and completed this questionnaire. Any questions I had were answered to my satisfaction.

Signature: _____ Date: _____

Signature of Parent/Guardian _____ Date: _____
(for participants under the age of majority)

INFORMED CONSENT FOR EXERCISE PARTICIPATION

- I desire to engage voluntarily in the Davidsville HealthStyles exercise program.

- I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory system and to thereby attempt to improve its function. However, the cardiorespiratory system response to exercise can not be predicted with complete accuracy. There is a risk of certain changes that might occur during the following exercise. These changes might include abnormalities of blood pressure or heart rate.

- I understand that the purpose of the exercise program is to develop and maintain cardiorespiratory fitness, body composition, flexibility, muscular strength and endurance. Specific exercise programs are available based on my needs, interests, and if necessary my doctor's recommendation. All exercise programs include warm-ups, exercising at target heart rate, followed with a cool down period. The programs may involve walking, jogging, swimming or cycling; participation in exercise fitness, rhythmic aerobic exercises, or choreographed fitness classes; or calisthenics or strength training. All programs are designed to place gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by exercise target heart rate and perceived effort of exercise.

- I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I shall cease my participation and inform the instructor/staff member of the symptoms.

- I agree to assume the risk of exercise and further agree to hold exempt Davidsville HealthStyles and its staff members conducting the exercise program from any and all claims, such losses, or related cause of action for damage, including, but not limited to, such claims that may result in injury or death, accidental or otherwise, during or arising in any way from the exercise program.

- I agree to inform my spouse and/or children (if applicable) of all Davidsville HealthStyles terms and conditions of membership rules, regulations, and policies.

- I affirm that I have read this form in its entirety and that I understand the nature of an exercise programs. I also agree that my questions regarding an exercise program have been answered to my satisfaction.

- In the even that medical clearance must be obtained prior to my participation in an exercise program, I agree to consult my physician and obtain written permission from my physician or sign an assumption of risk form prior to the commencement of exercise.

Member's Signature: _____ Date: _____

Member's Printed Name: _____

Signature of Parent / Guardian: _____ Date: _____
(for participants under the age of majority)

Davidsville HealthStyles strongly recommends an equipment orientation to all new members. The orientation is done to provide the member(s) proper instruction on how to use the exercise equipment safely and effectively.

Right of refusal for orientation sessions with the trainer.

Signature: _____ Date: _____

PAYMENT PLAN OPTIONS

Name: _____

Option A: Pay in Full Pay in full and receive one free month membership.

Paid in full and over 65 receive one free month.

☐ Cash

☐ Check (Please make check payable to **CSSMCW**)

☐ Discover ☐ Master Card ☐ Visa

Pay Monthly

Individual $25
Couple $40
Family $55

Card #: _____ Exp. Date: _____

Signature: _____ Date: _____

Option B: Automatic Monthly Debit

☐ Checking ☐ Savings

Bank Name _____

Routing Number _____

Account Number _____

Signature _____

Automatic Monthly Debit

Individual $25
Couple $40
Family $55

ALL accounts are billed after the 25th of the month for the following month.

Please Note: A $15 fee will be charged to your account for insufficient funds.

☐ Discover ☐ Master Card ☐ Visa

Card # _____ Exp. Date _____

Signature _____ Date _____

This authority is to remain in full force and effect until Davidsville HealthStyles and Bank have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Davidsville HealthStyles a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to Bank prior to charging account. After account has been charged, a customer has the right to have the amount of an erroneous debit immediately credited to his account by Bank up to 15 days following issuance of statement or 45 days after posting, whichever occurs first.

I have received a copy of the Davidsville HealthStyles Terms and Agreements Contract. I agree to inform my spouse and/or children (if applicable) of all Davidsville HealthStyles Terms and Conditions of Membership Rules, Regulations and Policies. By virtue of Davidsville HealthStyles membership, a member agrees to abide by all Terms and Conditions of Membership and Rules, Regulations and Policies.

I (we) hereby authorize and direct Chan Soon-Shiong Medical Center at Windber's Davidsville HealthStyles to initiate debit entries to my (our) Checking/Savings account indicated above and the bank named, to debit the same to such account for prepayment of monthly dues or other unpaid charges. The account will be debited after the 25th of the month for the following month.

I (we) hereby authorize and direct Chan Soon-Shiong Medical Center at Windber Portage HealthStyles to charge my (our) credit card account indicated above for payment of monthly dues or other unpaid charges

Signature: _____ Date: _____

Thank you and we look forward to assisting you in attaining your health goals!