Chan Soon-Shiong Medical Center at Windber

# HealthStyles New Membership Application & Agreement

Applicant Name	st)	(First)	[	Circle Men <b>Packages</b>		
Home Address				Individual		(\$36/mo)
City/State/Zip				Couple	\$720	(\$60/mo)
				Family	\$840	(\$70/mo)
Date of Birth	Age	e Sex	MF	Packages		Monthly
Employer	Occupatio	on		Student (14-18 y	0)	\$15
				Young Adult (	19-25 yo)	\$25
Home Phone	Work Phon	e		Individual		\$40
E-mail				Early Cancell	lation Fe	ee - \$50
How did you learn about Heal	IthStyles Fitness Cer	nter?				
Primary Care Physician			Physiciar	n Phone		
Health Insurance		Emergency C	ontact _			
Relationship to Member		Emergency	Contact	Phone		
Payment Options (Please Initio	al Choice)					
Annual Membership P	aid In Full	Credit Card	Debit	Amoun	t:	\$
Bank Draft, Checking		Bank Draft, S	avings	Monthly	Dues	

Acceptance and approval by Health*Styles* 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.

Your membership at Health*Styles* is a <u>one-year automatically renewing agreement</u>, payable annually or on a monthly basis. Membership constitutes a contractual commitment to pay dues on a yearly basis. Withdraws from the facility, except for the detailed reasons listed under "Additional Rights to Cancellation," will not relieve a member from fulfilling his/her annual obligation. A \$50 early cancellation fee will apply. This yearly membership agreement is automatically renewable, without notice, each year unless written notice of intent to cancel by either party is received at least thirty (30) days prior to the anniversary date. This notice must be dated, signed. Cancellation will then become effective on your anniversary date. \_\_\_\_\_ (Please Initial)

#### 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) Health*Styles* may retain this application form whether or not it is approved; (3) Health*Styles* 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 <u>and</u> the enclosed Terms and Conditions of Membership and the Rules, Regulations and Policies.

## **HealthStyles Payment Options**

Name	Date of Birth
Option A: Pay in Full	Pay in Full
Cach	Annual Individual \$432
Cash	Annual Couple \$720
Check (Payable to Chan Soon-Shiong Medical Center at Wind	lber) Annual Family \$840
Discover MasterCard Visa	Early Cancellation Fee - \$50
Card # Exp. Date	
Signature Date	
Option B: Automatic Monthly Debit	Automatic Monthly Debit
	Monthly Individual \$36
Checking Savings	Monthly Couple \$60
Bank Name	Monthly Family \$70
Routing Number	Early Cancellation Fee - \$50
Account Number	All accounts are billed after the 25th of the month
Signature Date	
Discover MasterCard Visa	Please Note: A \$15 fee
Card # Exp. Date	
Signature Date	funds.

This authority is to remain in full force and effect until Health*Styles* 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 Health*Styles* 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 HealthStyles Terms and Agreements Contract. I agree to inform my spouse and/or children (if applicable) of all HealthStyles Terms and Conditions of Membership Rules, Regulations, and Policies. By virtue of 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 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's Health*Styles* to charge my (our) credit card account indicated above for payment of monthly dues or other unpaid charges.

Signature \_\_\_\_\_

Date

THANK YOU! WE LOOK FORWARD TO ASSISTING YOU IN ATTAINING YOUR HEALTH GOALS!

# HealthStyles New Member Health Questionnaire

Name	Date of Birth	Age	Sex M F
Home Address	City/State/Zip	)	
Phone Health Insurance			
Physician	Date	of Last Physical _	
RISK FACTORS		_Stroke Family History of H	leart Disease
How would you rate your present level of fitness	? Poor Fair A	verage Good	Excellent
Do you take any medications prescribed by you	r physician? Yes	No	
If yes, please specify			
Are you currently being treated for any heart pro	oblems? Yes No		
If yes, please explain			
Do you have a history of heart problems? Ye Heart Attack Pacemo Bypass Surgery Valve Re	eplacement		
Have you ever had a stress test? Yes No			
Have you ever had a cardiac catheterization?			
Are you currently involved in a physical or occur			)
If yes, please explain			
Have you had any surgeries in the past six month			
If yes, please explain			
PHYSICAL ACTIVITY READINESS     Yes   No   1. Has your doctor ever said that you physical activity recommended by     Yes   No   2. Do you feel pain in your chest whe	/ a doctor? n you do physical activ	ityś	
Yes No 3. In the past month, have you had c			
Yes No 4. Do you lose your balance because Yes No 5. Do you have a bone or joint proble physical activity?	,		
Yes No 6. Is your doctor currently prescribing or heart condition?			ood pressure
Yes No 7. Do you know of any other reason w	, ,		
If yes, please explain			
I have read, understood, and completed this quimy satisfaction.	estionnaire. Any questic	ons I had were ans	swered to
Signature		_ Date	

Witness \_

## HealthStyles Informed Consent for Exercise Participation

- I desire to engage voluntarily in the 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 by 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 such exercise and further agree to hold exempt HealthStyles and its staff members conducting the exercise program from any and all claims, such losses, or related causes 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 HealthStyles terms and conditions of membership and rules, regulations and policies.
- I affirm that I have read this form in its entirety and that I understand the nature of an exercise program. I also agree that my questions regarding an exercise program have been answered to my satisfaction.
- In the event that a 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 Name Printed		

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.

Member's Signature

Date \_