HealthStyles New Membership Application & Agreement

Applicant Name _____
(Last) (First)

Home Address _____

City/State/Zip _____

Date of Birth _____ Age _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

E-mail _____

Circle Membership Type

Packages	Yearly
Individual	$432 ($36/mo)
Couple	$720 ($60/mo)
Family	$840 ($70/mo)

Packages	Monthly
Student / Young Adult	$15 / $25
Individual	$40

Early Cancellation Fee - $50

How did you learn about Health*Styles* Fitness Center? _____

Primary Care Physician _____ Physician Phone _____

Health Insurance _____ Emergency Contact _____

Relationship to Member _____ Emergency Contact Phone _____

Payment Options (Please Initial Choice)

_____ Annual Membership Paid In Full _____ Credit Card Debit Amount: $_____

_____ Bank Draft, Checking _____ Bank Draft, Savings 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 one-year automatically renewing agreement, 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 and the enclosed Terms and Conditions of Membership and the Rules, Regulations and Policies.

Applicant's Signature _____ Date _____

HealthStyles Payment Options

Name _____ Date of Birth _____

Option A: Pay in Full*

Pay in Full	
Annual Individual	$432
Annual Couple	$720
Annual Family	$840

Early Cancellation Fee - $50

**When annual membership is paid in full, you will receive one month of membership for free.*

○ Cash

○ Check *(Payable to Chan Soon-Shiong Medical Center at Windber)*

○ Discover ○ MasterCard ○ Visa CVV# _____

Card # _____ Exp. Date _____

Signature _____ Date _____

Option B: Automatic Monthly Debit

Automatic Monthly Debit	
Student/Young Adult	$15 / $25
Individual	$40
Couple	$60
Family	$70

Early Cancellation Fee - $50

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.

○ Checking ○ Savings

Bank Name _____

Routing Number _____

Account Number _____

Signature _____

○ Discover ○ MasterCard ○ Visa CVV# _____

Card # _____ Exp. Date _____

Signature _____ Date _____

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 Health*Styles* Terms and Agreements Contract. I agree to inform my spouse and/or children (if applicable) of all Health*Styles* Terms and Conditions of Membership Rules, Regulations, and Policies. By virtue of Health*Styles* 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 Health*Styles* 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 _____

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

☐ Smoking
☐ High Cholesterol
☐ High Blood Pressure
☐ Sedentary/Inactive
☐ Diabetes
☐ Obesity
☐ Stroke
☐ Family History of Heart Disease

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 history of heart problems? ○ Yes ○ No

☐ Heart Attack
☐ Bypass Surgery
☐ Pacemaker
☐ Valve Replacement
☐ Angioplasty
☐ Stent Placement

Have you ever had a stress test? ○ Yes ○ No If yes, when? _____

Have you ever had a cardiac catheterization? ○ Yes ○ No If yes, 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 six months? ○ Yes ○ No

If yes, please explain _____

PHYSICAL ACTIVITY READINESS

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?

Yes ○ No ○ 2. Do you feel pain in your chest when you do physical activity?

Yes ○ No ○ 3. In the past month, have you had chest pain when you were not doing physical activity?

Yes ○ No ○ 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes ○ No ○ 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Yes ○ No ○ 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

Yes ○ No ○ 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 _____ Witness _____
(for participants under the age of 18)

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 _____

HealthStyles Physician's Consent Form for Exercise Participation

My patient, _____, has expressed an interest in participating in a voluntary exercise program at Health*Styles* Fitness Center located at Chan Soon-Shiong Medical Center at Windber. My signature indicates that I am aware this patient will be appropriately orientated to the exercise equipment by a certified/degreed staff person. I am approving my patient's request and agree that he/she is medically stable and able to participate in the exercise program at Health*Styles*.

Physician's Signature _____ Date _____

Physician's Name Printed _____