Maple Knoll Village
Hemsworth Wellness Center
Membership Contract

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Healthways SilverSneakers® Fitness Program

MindBody#_____ Employee#_____

Date: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ ZIP: _____

Phone: _____ Email: _____ Male: ____ Female: _____

Emergency Name & Phone Number: _____

Physician Name: _____ Physician #: _____

MKC Status (please circle)

Independent Living Assisted Living Community Member Employee Meadows

Please select your membership option below

Resident - *Free

	Prepay	**Draft**
Community Single	$_____	$_____
Community Couple	$_____	$_____
Meadows Single	$_____	$_____
Meadows Couple	$_____	$_____
Employee Single	$_____	$_____
Employee Couple *Add $40 for each additional member	$_____	Payroll Deduct $_____
Silver Sneakers	Basic $_____	+ $20/month, $30/couple

Start Date of Contract: _____ Expiration Date: _____

$ _____ + $ _____ = $ _____

Yearly Dues Tax Total Due

Member Signature: _____ Date: _____

Wellness Center: _____ Date: _____

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Physician's Consent Form

Information Request for: _____

I. Physician Name: _____ Physician's License #: _____

Physical Health Status - *Please indicate health status:*

	#	Low	Normal	High
Height		-	-	-
Body Weight		L	N	H
Resting Heart Rate		L	N	H
Blood Pressure		L	N	H

May individual use a 104 degree whirlpool/spa?	Yes	No
Time Limit:	(Max of 10 minutes)	

II. Physician's Statement of Restrictions (if any)

The above named individual may participate, without restriction, in all activities offered at the Hemsworth Wellness Center.

The above named individual may participate, with restriction, in limited activities offered at the Hemsworth Wellness Center. (Fitness & aquatic staff will design a physical activity program for the individual based on the stated physical restrictions.)

Restriction and justifications:

_____

_____

The above named individual **may not participate** in physical activities offered at the Maple Knoll Wellness Center.

III. This consent form is valid for 12 months.

Phone number: _____ Fax number: _____

Physician's Signature: _____ Date: _____

Wellness Center Member Statement (Signature/Date?

_____/_____ I have read or been informed of the above Physician's Consent Form. I agree to adhere to any restrictions or limitations noted.

_____/_____ I have completed the Health & Wellness Questionnaire and **WAIVE** the recommendations to provide a completed Physician's Consent Form.

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Health & Wellness Questionnaire

Please Note

At The Hemsworth Wellness Center, our programs are designed for your comfort and enjoyment.

Please go at your own pace and do only as you are able. If you feel uncomfortable at any time during any program, we encourage you to inform the instructor and, if necessary, you may leave at any time. If there are circumstances or accommodations we could make so that your participation in our Wellness Program is both comfortable and enjoyable, please notify our fitness staff for any suggestions you have.

Renewing Members Only: Have you had ANY previous condition changes or have ANY NEW conditions developed within the last year? Yes _____ No _____

If yes, please indicate below. If no, you may stop here.

	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 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 blood pressure or heart condition?
7			Do you know of any other reason why you should not do physical activity?

If you marked yes to one or more questions: Talk with your doctor by phone or in person BEFORE you start becoming much more physically active. Inform them of any of the question of which you answered yes.

You may be able to do any activity that you want—as long as you start slowly and build up gradually. Or you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kind of activities you wish to participate in and follow their advice.

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AHA/ACSM Health/Fitness Facility Pre-Participation Screen Questionnaire

Please mark each statement that applies to your health status

Have You Had:

_____ Heart Attack

_____ Heart Surgery

_____ Cardiac catheterization coronary

_____ Angioplasty (PTCA)

_____ Pacemaker/implantable cardiac defibrillator

_____ Rhythm disturbance

_____ Heart valve disease

_____ Heart failure

_____ Heart transplantation

_____ Congenital heart disease

_____ Joint replacement

Specify: _____

Year: _____

Hearing:

Do you have a hearing impairment?
Yes _____ No _____
Do you wear a hearing aid?
Yes _____ No _____

Vision:

Do you have a vision impairment?
Yes _____ No _____
Are you able to read newsprint?
Yes _____ No _____

Primary Device Used:

None _____ Walker _____

Wheelchair _____ Cane _____

Cardiovascular Risk Factors:

_____ You smoke
_____ Your blood pressure is >130/90
_____ You do not know your blood pressure
_____ You take blood pressure medication
_____ Your blood cholesterol level is >200
_____ You do not know your cholesterol level
_____ You are physically inactive (i.e., you get <30 mins of physical activity on at least 3 days/week)
_____ You are greater than 20 pounds overweight
_____ You are none of the above

Other Health Issues:

_____ You have diabetes
_____ You have asthma or other lung disease
_____ You have burning or cramping sensation in your lower legs when walking short distances
_____ You have musculoskeletal problems that limit your physical activity
_____ You have concerns about the safety of exercise
_____ You take prescription medications

Specify:_____

_____

Goals:_____

_____

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Assumption of Risk
(Please Read Carefully)

I assume all the risks of using the Hemsworth Wellness Center. I voluntarily and knowingly participate in any or all of the programs sponsored at the Hemsworth Wellness Center.

Additionally, I voluntarily waive any and all present and future claims resulting from negligence.

For myself and my heirs, assigns, beneficiaries, estate, and legal representatives, I hereby release and indemnify the Hemsworth Wellness Center, its affiliates, officers, trustees, agents, employees, representatives, successors and assigns from any and all claims of whatever nature arising from my death, personal injury or property damage related to my use of the Hemsworth Wellness Center or participating in aquatic programming, resistance training, cardio respiratory endurance training, body awareness, and wellness programming; or in any activities incidental to such aquatic programming, resistance training, cardio respiratory endurance training, body awareness, and wellness programming. This release shall remain in full force and effect for the entire length my membership is valid.

I hereby acknowledge that I may have health/medical limitation that could be discovered during the fitness assessment/physician clearance process that could affect or deter my ability to withstand strenuous exercise, or to place stress on any specific part of my body. I hereby consent and agree to assume all responsibility for any and all risks of injury with respect to such physical conditions, and my current health status.

Name (Print): _____ Date: _____

Name (Signature): _____

Wellness Center Staff: _____ Date: _____

PLEASE TAKE IN CONSIDERATION

If you marked two or more of the statements in the Health Questionnaire (PARQ) section, the center recommends an exercise program at The Hemsworth Wellness Center with a professionally qualified Personal Trainer.

TO SET UP AN APPOINTMENT PLEASE CALL:

513-782-4340

Waiver and Assumption of Risk

Please consult with your physician before beginning any exercise program.

I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the "Programs"). I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue any class instructor, any Healthways participating location, any sponsoring organization, Healthways, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read and understand this waiver and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location or individual.
In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs.

- Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Diabetes
- Previous hip or spinal fracture (as an adult)
- Lung disease or shortness of breath after mild exertion, at rest, or in bed
- Open cuts on my feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- More than two falls in the past year (no matter what the reason)
- More than one year since I have engaged in regular physical activity

Member Name (Print): _____ Date: _____

Emergency Contact Name: _____ Contact Number: _____

Member Signature: _____

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Please select your membership option below

X	Membership	Start Date	Expiration Date
	Community Single (Prepay) - ($432)		
	Community Couple (Prepay) - ($518)		
	Community Single (Auto Deduct $40)		
	Community Couple (Auto Deduct - $60)		
	Meadows Single (Prepay) - ($216)		
	Meadows Single (Auto Deduct - $18)		
	Silver Sneakers Plus—Single ($20/mo)		
	Silver Sneakers Plus—Couple (30/mo)		
	Silver Sneakers Basic - Free		
	Daily/Class Rate $10		

	Individual Employee Membership	$7.38/PP
	Couple Employee Membership	$8.92/PP