

Nash Hospitals Inc.
Health*First* Fitness Center
Membership Application

Please print this form and complete the following information to help us better serve you:

Name: (Last) (First) (MI)

_____/_____/_____
(Birthdate) (Age) (M/F) _____
(Daytime Phone No.) (Evening Phone No.)

(E-mail Address) (Fax No.)

(Mailing Address) (City) (State) (Zip)

(Billing Address – if different) (City) (State) (Zip)

(Employer/Business Name) (Position/Job Title)

(Emergency Contact Name) (Relationship) (Phone No.)

(Personal Physician) (Office/Fax No.)

Please check any of the following activities you might be interested in:

- | | | |
|--|--|---|
| <input type="checkbox"/> Group Exercise/Aerobics Classes | <input type="checkbox"/> Flexibility Classes | <input type="checkbox"/> Strength Training Equipment |
| <input type="checkbox"/> Water Exercise Classes | <input type="checkbox"/> Strength Training Exercises | <input type="checkbox"/> Cardiovascular Equipment |
| <input type="checkbox"/> Strength/Endurance Classes | <input type="checkbox"/> Cardiovascular Exercises | <input type="checkbox"/> Mind/Body Classes (Yoga/Pilates) |

Please check any of the following services you might be interested in:

(* - additional cost)

- | | | |
|--|--|---|
| <input type="checkbox"/> Fitness Testing/Evaluation* | <input type="checkbox"/> Group Exercise/Aerobics Classes | <input type="checkbox"/> Support Groups (Cardiac/Pulmonary) |
| <input type="checkbox"/> Water Exercise Classes* | <input type="checkbox"/> Nutrition Counseling* | <input type="checkbox"/> Smoking Cessation* |
| <input type="checkbox"/> Personal Training* | <input type="checkbox"/> Weight Loss Program* | <input type="checkbox"/> Mind/Body Classes (Yoga/Pilates) |
| <input type="checkbox"/> Healthy Back Program | <input type="checkbox"/> Arthritis Program | |

What time are you most likely to exercise:

- 6am 8am 10am 12pm 2pm 6pm

What is your primary reason for joining HealthFirst Fitness Center?

How did you find out about HealthFirst Fitness Center?

- Friend is a member Cardiac Rehab Graduate Newspaper Ad
 Family member/spouse is a member Pulmonary Rehab Graduate Radio Ad
 Was a former member Physician Referral NHCS Web Page
 NHCS Employee Special Promotion (please specify):

PLEASE READ CAREFULLY BEFORE SIGNING:

I certify that all statements made on this application are accurate and that my answers to questions on the medical screening questionnaire are complete and true to the best of my knowledge. I understand that any misrepresentation or misinformation in this application/questionnaire could result in my rejection of my application, and could ultimately result in revocation of my membership. I understand that, based on my current symptoms or medical condition, I may require to have a clearance from a physician, including a baseline medical examination and/or exercise stress test or screening fitness test before my membership application can be accepted. I understand that additional costs may be incurred based upon services rendered. I understand that all fees, including membership and all additional costs from services provided, are due at time of membership or date of service. Membership fees are renewable upon expiration and all joining and membership fees are non-refundable.

Participation in a regular program of physical activity has been shown to produce positive physiological adaptations. These adaptations may cause changes that include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility and endurance.

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiovascular system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those indicated on the Health History Questionnaire) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

By signing this consent I understand that I am personally responsible for my actions throughout the duration of my exercise program, and that I waive the responsibility of HealthFirst Fitness Center and Nash Health Care Systems, its officers, employees, agents, or representatives, if I should incur any injury of any nature whatsoever as a result of my participation in any exercise program suggested or offered by HealthFirst Fitness Center and Nash Health Care Systems, its officers, employees, agents, or representatives.

Member Signature: _____ Date _____

Witness's Signature: _____ Date _____

Nash Hospitals Inc.
HealthFirst Fitness Center

Informed Consent for Participation in Exercise Programming

Member Name _____

1. Purpose and Explanation of Procedure

I hereby consent to voluntarily engage in an acceptable plan of exercise conditioning through the HealthFirst Fitness Center. I also give consent to be placed in exercise activities, programs, or other recreational activities that are recommended to me for improvement of my general health and well being. I will be given instructions regarding the amount and kind of exercise I should do. Professionally trained personnel will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes my doctor or I make with regard to use of these. In addition, recommendations that may be made by the exercise specialist are educational in nature and are not intended to replace sound medical advice that I may receive from my personal physician.

2. Risks

I understand and have been informed that there exists the remote possibility during exercise of adverse changes some of which include abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instances of heart attack, stroke, or even death. Every effort will be made to minimize these occurrences by 1) proper staff assessment of my condition before each exercise session, and 2) my own careful control of exercise efforts; both of which I am responsible for obtaining. I have also been informed when emergency equipment and personnel are available to deal with unusual situations should these occur. I understand that there is a risk of injury, heart attack, or even death as a result of my exercise, but knowing those risks, I desire to participate as herein indicated.

3. Benefits to be Expected and Alternatives Available to Exercise

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort within my personal limitations. I further understand that if I closely follow the program instructions, I will likely improve my exercise capacity after a period of 3 to 6 months.

4. Confidentiality and Use of Information

I have been informed that the information obtained in this exercise program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. Notwithstanding, I understand and agree that such confidential information may be provided to my personal physician. I do, however, agree to the use of any information that is not personally identifiable with me for research and statistical purposes so long as it does not identify me or provide facts that could lead to my identification. Any other information obtained, however, will be used only by the program staff in the course of recommending exercise for me and evaluating my progress in the program.

_____ Initials

5. Responsibility of the Participant

To promote safety and gain benefit, I must give priority to regular attendance and adherence to the recommended intensity, duration, frequency, progression, and type of activity. To achieve the best possible care:

I WILL NOT

- Withhold any information pertinent to symptoms from any staff member.
- Exercise when I do not feel well.
- Exercise within 2 hours after eating or using tobacco products or alcohol.

I WILL

- Report any unusual symptoms that I experience before, during, or after exercise (I may help assure the safety and well being of others in the program if I also report any unusual symptoms I notice in other patrons).
- Check in with the staff.
- Follow, without exception, all recommendations made by staff concerning the limits on any exercise, weight control, or health-related activities, which I may be encouraged to do and document by recordings.

6. Financial Responsibility

I agree to pay a one time joining fee of \$_____ and a monthly fee of \$_____ to Nash Hospitals Inc. for a period of 3 months or 1 year. The joining fee will include an assessment of blood pressure and heart rate, exercise recommendations as well as a complete orientation to exercise equipment unless I prefer to waive those services. These fees are due and payable at the time of membership, and are renewable upon expiration. I understand that joining and membership fees are nonrefundable.

7. Inquiries and Freedom of Consent

I have been given an opportunity to ask certain questions as to the procedures of this program. I further understand that there are also other remote risks that may be associated with this program. Despite the fact that an incomplete accounting of remote risks has been provided to me, I still desire to participate.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read the same.

I consent to the rendition of all services and procedures as explained herein by all program personnel.

Participants Signature _____ **Date** _____

Witness's Signature _____ **Date** _____