

WELLNESS CENTER INFORMATION AND REGULATIONS

Mission Statement: ◆ To ensure a safe and comprehensive transition from injury or illness to overall fitness and well being.

Hours of Operation: ◆ 7:00 AM – 8:00 PM Mon. – Fri.
 ◆ 8:00 AM – 4:00 PM Sat.
 ◆ Closed Major Holidays

Supervision and Staff:

- ◆ This is an independent center for members
- ◆ If under 16 years of age - must be accompanied by parent
- ◆ If under 18 years of age - must have signed consent from parent
- ◆ There must be an authorized staff member in the clinic
- ◆ Personal training sessions are made by appointment with the Exercise Physiologist
- ◆ Sign-in on the "sign-in" sheet at entrance
- ◆ Members are responsible for personal belongings - you may bring a lock to utilize lockers
- ◆ Children may not accompany you - there is no daycare
- ◆ Non-members must wait in the waiting room
- ◆ Should you have any questions or concerns, please see the Exercise Physiologist

Availability of Equipment:

- ◆ Priority must be given to current physical therapy patients, therefore, you might be asked to limit your time on a piece of equipment for treatment use

Fees:

- ◆ Visits/consultations/appointments with Physical Therapists must be scheduled in advance
- ◆ Fees for these visits will vary based on services rendered and are due at time of service
- ◆ Additional personal training sessions:
 - \$40 per ½ hour
 - \$70 per hour
- ◆ Pilates sessions:
 - \$75 per hour



RELEASE OF LIABILITY

I, _____, have volunteered to participate in a progressive exercise program at facilities provided by Seneca Wellness and Fitness Center, LLC, and the program has been fully explained to me. In consideration of my participation in the exercise program, I hereby release Seneca Wellness and Fitness Center, LLC, its shareholders, board of directors, officers, agents, administrators, and employees of all liability for injuries or accidents which may occur during or as a result of my use of such facilities or my participation in such exercise program. I hereby agree to indemnify and hold harmless Seneca Wellness and Fitness Center, LLC, its shareholders, board of directors, officers, agents, administrators, and employees for all causes of action, claims for damages and demands which may be made with respect to any such injuries or accidents.

I further agree to follow any limitations in activity and for equipment use required for my safety. I understand that the risks normally associated with the use of any exercise program and fitness equipment are increased for anyone who is injured, physically compromised, or under medication and I accept full responsibility for my participation in the program.

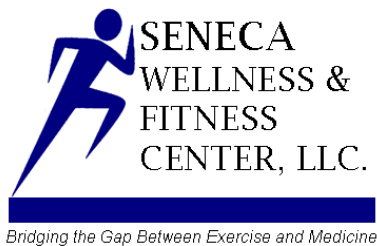
I fully realize the risks associated with the exercise program and fitness equipment and I intend this to be a complete release of Seneca Wellness and Fitness Center, LLC, its shareholders, board of directors, officers, agents, administrators, and employees from any liability.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND THE FOREGOING RELEASE AND SIGN AS MY OWN FREE ACT.

Client

Witness

Date



**AHA/ACSM Health/Fitness Facility
Pre-participation Screening Questionnaire:**

Name: _____ Home Phone: (____) _____ - _____
 Address: _____ Work Phone: (____) _____ - _____
 City: _____ State: _____ Zip: _____ Cell Phone: (____) _____ - _____
 Sex: M _____ F _____ Age: _____ DOB: _____ e-mail address: _____

Emergency Contact:
 Name: _____ Phone: _____
 Relationship: _____ Phone: _____
 Name of your physician: _____

Are you currently under a doctor's care? Yes No
 If yes, explain: _____

Date of last physician checkup: _____
 Have you ever had a stress test? Yes No Don't Know
 If yes, what were the results? Normal Abnormal Don't Know

Do you take any medications on a regular basis? Yes No
 If yes, please list the medications and reasons for taking: _____

Have you been recently hospitalized? Yes No
 If yes, please explain: _____

Section I

History: Have you had:

A heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Cardiac Catheterization	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Coronary Angioplasty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Pacemaker, implantable cardiac defibrillator, or rhythm disturbance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart valve disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart transplantation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

Symptoms

You experience chest discomfort with exertion.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
You experience unreasonable breathlessness.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
You experience dizziness, fainting, blackouts.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
You take heart medications.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

According to the American College of Sports Medicine, if you marked any of the statements in section I, consult your health care provider before engaging in exercise.

Section 2

Cardiovascular risk factors

You are a man ≥ 45 years.

Yes No

You are a woman ≥ 55 years, you have had a hysterectomy, or you are postmenopausal.

Yes No

Are physically inactive (you get less than 30 min. of Physical activity on at least 3 days/week.)

Yes No Don't know

Are more than 20 pounds overweight.

Yes No Don't know

You have

High Blood Pressure

Yes No Don't know

High Cholesterol

Yes No Don't know

Stroke

Yes No Don't know

Have parents or siblings who, prior to age 55, had:

Heart attack

Yes No Don't know

High Blood Pressure

Yes No Don't know

High Cholesterol

Yes No Don't know

Diabetes

Yes No Don't know

Stroke

Yes No Don't know

You Have

Diabetes

Yes No Don't know

Irregular heartbeat or palpitations

Yes No Don't know

Rheumatic heart disease

Yes No Don't know

Emphysema

Yes No Don't know

Epilepsy

Yes No Don't know

Asthma

Yes No Don't know

Are pregnant

Yes No Don't know

Currently Smoke

Yes No Don't know

Other metabolic disorders (thyroid, kidneys, etc.)

Yes No Don't know

If yes, please explain: _____

You have concerns about the safety of exercise.

Yes No Don't know

You have musculoskeletal problems.

Yes No Don't know

If yes, please explain: _____

According to the American College of Sports Medicine, if you marked two or more of the statements in section 2, you should consult your health care provider before engaging in exercise.

None of the issues listed in sections 1 or 2 above are true for me.

Yes

According to the American College of Sports Medicine, if you said yes to the statement above you should be able to exercise safely without consulting your health care provider.

I attest that the above information is true to the best of my knowledge and acknowledge that I understand the information will be utilized for fitness assessment purposes. I realize that if the information is incorrect it may result in harm to me.

Signature _____

Date _____

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

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

If
you
answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity 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 kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active — begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal — this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever — wait until you feel better; or
- if you are or may be pregnant — talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

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

NAME _____

SIGNATURE _____

DATE _____

SIGNATURE OF PARENT _____

WITNESS _____

or GUARDIAN (for participants under the age of majority)

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.





CANCELLATION POLICY

Please be on time. Our time and your time is valuable. We want to be able to provide to you the best care we can. If you are late that affects how much we are able to work with you and how much you get out of our time together.

- ⇒ I agree to give 24 hours notice prior to my appointment time in the event of a cancellation.
- ⇒ If I am unable to cancel without proper notice, I will pay the **full** amount for my session. It is understood there may be medical or family emergencies, which may prevent me from giving 24 hours notice - these will be handled on a case-by-case basis.
- ⇒ If I am late, my session will still finish on time.
- ⇒ My health and fitness professional agrees to give me 24 hours notice prior to being unable to keep an appointment.
- ⇒ If my health and fitness professional is unable to cancel without proper notice, I will receive **one equal** session free. It is understood there may be medical or family emergencies, which may prevent them from giving 24 hours notice.

Thank you for your understanding and consideration.

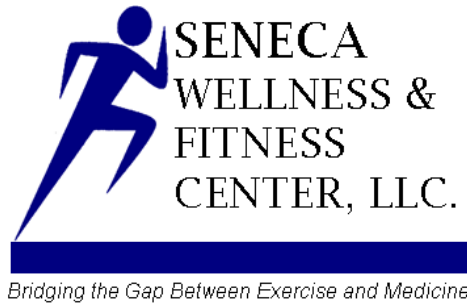
Best in health,
Seneca Wellness & Fitness Center Staff

Client Signature

Date

Witness Signature

Date



Automatic Credit Card Billing Authorization Form

I, _____ authorize Seneca Wellness & Fitness Center, LLC. (Wellness) to keep my signature on file and to charge my account for recurring (on-going) monthly fees not to exceed \$ 60.00.

Charges of \$ _____ are to occur on the 1st day of each month starting _____.
(date)

I assign my credit card account number to Wellness. I understand that this form is valid until I give a 30-day written notice to cancel the authorization to Wellness.

Client's Name _____

Card Holder's Name _____
(as shown on credit card)

Card Holder's Address _____

City _____ State _____ Zip _____
(billing address – required)

Visa MasterCard Other _____

Acct. # _____ Exp. Date _____ / _____

Signature _____

Questions & Answers

- Q. May I set a limit for the amount Wellness can automatically bill?
 A. Yes. The amount is indicated in the appropriate section of the form.

- Q. Will I receive a statement or receipt for the charges automatically billed to my card?
 A. You will receive a copy of this Credit Card Authorization Form. All authorized charges will appear on your monthly statement, just like any other purchase.

- Q. What is an automatic billing procedure?
 A. It is a convenient payment method in which you authorize Wellness to automatically bill your credit card for recurring monthly charges. All charges must be in accordance with your agreement.

- Q. How does the automatic billing procedure work?
 A. The form is used to automatically bill your account for recurring fees. Simply specify the amount, frequency and start date on the form.

- Q. How do I cancel automatic billing?
 A. Provide a written 30-day notice to Wellness.