DeKalb Medical
Wellness Center

DeKalb Medical Wellness Center
2665 North Decatur Road, Suite G10
Decatur, Georgia 30033

New Member Checklist

- **Application**
- **Q & A and Member Type agreement**
- **Health History Survey**
- **Agreement and Release of Liability**
- **Protected Health Information Form**

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Membership Application

Member # _____ Silver Sneakers # _____

Welcome! *The information you provide below will be entered into our computer, allowing a quick and easy check-in when you come to work out. You may update this information any time by contacting one of our Customer Service Representatives at the front desk.*

First Name: _____ MI: _____ Last Name: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ □ Male □ Female

Date of Birth: _____ Age: _____

Email Address: _____

Emergency Contact Information

Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

How did you hear about the Wellness Center? ***(Check as many as apply)***

□ DeKalb Medical Employee/Department **Name:** _____
□ DeKalb Medical Employee Orientation
□ Wellness Center Member **Name:** _____
□ Physician **Name:** _____
□ Website/Facebook **Name:** _____
□ Physician **Name:** _____
□ Direct mail
□ Other: Please explain: _____

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BUYER'S RIGHT TO CANCEL OR TERMINATE: Members have the right to cancel their membership. Cancellation must be in writing and delivered to The Wellness Center at DeKalb Medical either in person or by fax or mail. Month-to-month (electronic payment) members may voluntarily terminate membership and fill out a cancellation form at any time by: 1) notifying the Wellness Center at DeKalb Medical in writing by mail or in person 30 days prior to cancellation and; 2) paying all current charges prior to termination.

SUSPENSION/TERMINATION OF MEMBERSHIP BY MANAGEMENT: Management has the right to suspend and/or terminate any membership for non-payment of dues, fees, or for behavior inimical to the enjoyment of the DeKalb Medical Wellness Center by other members and staff for any reason deemed sufficient in the sole discretion of management.

PROVISIONS: The Wellness Center at DeKalb Medical will provide a fully equipped exercise facility including a fitness training area with stationary bicycles, elliptical, treadmills, circuit training equipment and free weight training area. The Wellness Center at DeKalb Medical may be unavailable during a period of repair and maintenance, certain holidays or by Management's discretion. In order to keep the facility in the best possible condition a portion of the Wellness Center at DeKalb Medical may be closed for a temporary time period for repairs and renovations. There will be no adjustment in dues for this period of closure.

DUES & FEES:
EFT Membership One time joining fee is due for new members at sign up. (After this, joining fee is waived if the member re-joins within 6 months). Dues will be automatically charged to member's bank account/debit/credit card on or around the 15th day of every month. If payment is reversed/declined a running balance is created. Member will be charged the current and past due balance on the next billing cycle. If paying through an automatic withdrawal from a bank draft or credit/debit card make sure to fill out EFT form and attach a voided check or a savings deposit slip that displays member name, account and routing number.

UNPAID BALANCES: Any unpaid balance for membership dues or fees, goods or services past 30 days will result in automatic suspension of membership privileges or cancellation of membership. Member agrees to pay all costs of collection, including but not limited to collection agency fees, court costs, administrative costs, disbursements and attorney's fees which may be paid or incurred by the Wellness Center at DeKalb Medical.

DISHONORED CHECK: If any check payable to the Wellness Center at DeKalb Medical is dishonored it will be assessed a $30 charge for each occurrence, and collect the current and past-due balance in any subsequent month.

CANCELLATION: ***Prepaid/PIF Membership Plans:*** if you cancel a prepaid/PIF (paid in full) membership plan, you will be refunded the pro-rated amount remaining of the membership. ***EFT Membership Plans:*** Continuous until you turn in a cancellation form. Allow 30 days for processing.

Membership Type	Joining Fee	*EFT Monthly Fee	Six months PIF	12 months PIF
Adult (16-59)	$75	$42	$240	$456
2 Adults (16-59)	$99	$80	$468	$912
Senior Adult (60+)	S50	$36	$204	$384
2 Senior Adults (60+)	$75	$68	$396	$768
Employee-North Decatur	N/A	$24	$143	$286
Employee-Hillandale	N/A	$11	$65	$130
Employee-Combo	N/A	$30	$182	$364
Corporate	$50	$36	$204	$384
DM Hospital Volunteers	N/A	$36	$204	$384
Silver Sneakers	N/A- No Fees for participating members			

*automatic withdrawal from a bank draft or credit/debit card

Membership Type: _____

Method of Payment: _____

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Physical Activity Readiness Questionnaire (PAR-Q)

PAR-Q is designed to help you help yourself. Many health benefits are associated with regular exercise, and the completion of PAR-Q is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people, physical activity should not pose any problems or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advise concerning the type of activity most suitable for them.

Common sense is your best guide in answering these few questions. Please read them carefully and check **YES** or **NO** opposite the question if it applies to you. If yes, please explain.

YES	NO	
____	____	1. Has your doctor ever said you have heart trouble? Yes, _____
____	____	2. Do you frequently have pains in your heart and chest? Yes, _____
____	____	3. Do you often feel faint or have spells of severe dizziness? Yes, _____
____	____	4. Has a doctor ever said your blood pressure was too high? Yes, _____
____	____	5. Has your doctor ever told you that you have a bone or joint problem(s), such as arthritis that has been aggravated by exercise, or might be made worse with exercise? Yes, _____
____	____	6. Is there a good physical reason, not mentioned here, why you should not follow an activity program even if you wanted to? Yes, _____
____	____	7. Are you over age 60 **and** not accustomed to vigorous exercise? Yes, _____
____	____	8. Do you suffer from any problems of the lower back, i.e., chronic pain, or numbness? Yes, _____
____	____	9. Are you currently taking any medications? If YES, please specify. Yes, _____
____	____	10. Do you currently have a disability or a communicable disease? If YES, Please specify, Yes, _____

If you answered NO to all questions above, it gives a general indication that you may participate in physical and aerobic fitness activities and/or fitness evaluation testing. The fact that you answered NO to the above questions is no guarantee that you will have a normal response to exercise. If you answered Yes to any 2 or more of the above questions, then DeKalb Medical Wellness Center will need written permission from a physician before you participate in physical and aerobic fitness activities and/or fitness evaluation testing.

_____ _____ _____

Print Name Signature Date

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Agreement and Release of Liability
For Members without Physician Clearance

Please initial all information below to confirm that you agree and understand the policies.

_____ In consideration of gaining membership or being allowed to participate in the activities and programs of the Wellness Center and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge DeKalb Medical, its subsidiaries and officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or may use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility.

_____ I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

_____ I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the Wellness Center or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a minimum of an annual physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given any physician's permission needed to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

_____I understand that the Wellness Center at DeKalb Medical enrolls and maintains memberships without regard to race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex, sexual orientation or age. It is DeKalb Medical's policy that any members with disabilities shall be entitled to reasonable accommodations for their physical and mental impairments. It is also DeKalb Medical Wellness Center's policy to adhere to equal opportunity for all and shall have the no discrimination on the basis of any of the aforementioned classifications. If I believe that I have been treated unfairly on any of the aforementioned matters then I should report the incident to the Wellness Center management.

Print Name: _____

Signature: _____

Witness (Wellness Center Staff) _____

DeKalb Medical Wellness Center

Authorization for Release of Protected Health Information

DeKalb Medical Wellness Center

Patient's Full Name: _____

Date of Birth: _____

Street Address: _____

Authorization for Release of Protected Health Information

I hereby authorize DeKalb Medical Wellness Center to release the following health information:

( ) My complete Wellness Center file

( ) Other: _____

and forward it to the following person/facility:

Person or Facility _____

Address (street, city, state, zip code)

_____

_____

_____

Phone #: _____ Email: _____

The information is for the purpose of:

_____

_____

This authorization is in effect until _____, when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my nidividually identifiable health information as described above for the purpose listed. I understand that authorization is voluntary.
- I understand the notice of the Privacies Practices provides instructions should I choose to revoke my authorization.
- I understand that if the organization I have authorized to receive the information is not a health plan or health care provided, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE:_____
DATE_____