Welcome!

New Member Checklist

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

Contact Information

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  Name: ___________________________

☐ Newspaper

☐ Radio

☐ Health Lines

☐ Yellow Pages

☐ Internet

☐ Physician  Name: ___________________________

☐ Wellness Center Calendar

☐ Wellness Center Member  Name: ___________________________

☐ Hospital Employee Orientation

☐ Other: Please explain: _______________________________________
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. All faxed and mailed cancellations will be dated 14 days from fax date or postmark. Dues for the final month will be pro-rated and billed during the final month. In the event of a three (3) day cancellation, The Wellness Center at DeKalb Medical will refund by pro-rating amount of membership that is left over. Month-to-month (electronic payment) members may voluntarily terminate membership at any time by: 1) notifying The Wellness Center at DeKalb Medical in writing by fax, mail or in person 30 days prior to cancellation and; 2) paying all current charges prior to termination. You may also cancel if the Member relocates more than 20 miles from The Wellness Center at DeKalb Medical.

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_ Dues will be automatically charged to Member’s bank account/debit/credit card on or around the 15th day of every month.

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 cancelation form. Allow 30 days for processing.

EQUAL OPPORTUNITY POLICY STATEMENT: 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. Any members with disabilities shall be entitled to reasonable accommodations for their physical and mental impairments. It is our policy that DeKalb Medical Wellness Center and its personnel adhere to equal opportunity for all and shall have the no discrimination on the basis of any of the aforementioned classifications. Any member who believes that he/she is/has been treated unfairly on any of the aforementioned matters should report the incident to The Wellness Center management.

<table>
<thead>
<tr>
<th>Types of Facility Membership</th>
<th>*EFT Monthly Fee</th>
<th>Six months PIF</th>
<th>12 months PIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (16-59)</td>
<td>$42</td>
<td>$240</td>
<td>$456</td>
</tr>
<tr>
<td>2 Adults (16-59)</td>
<td>$80</td>
<td>$468</td>
<td>$912</td>
</tr>
<tr>
<td>Senior Adult (60+)</td>
<td>$36</td>
<td>$204</td>
<td>$384</td>
</tr>
<tr>
<td>2 Senior Adults (60+)</td>
<td>$68</td>
<td>$396</td>
<td>$768</td>
</tr>
<tr>
<td>Employee –North Decatur</td>
<td>$24</td>
<td>$143</td>
<td>$286</td>
</tr>
<tr>
<td>Corporate</td>
<td>$36</td>
<td>$204</td>
<td>$384</td>
</tr>
<tr>
<td>DM Hospital Volunteers</td>
<td>$36</td>
<td>$204</td>
<td>$384</td>
</tr>
<tr>
<td>Silver Sneakers</td>
<td>No Fee for participating members</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Membership Type: ____________________________________________________________

Method of Payment: _________________________________________________________

If paying through an automatic withdrawal from a bank draft or credit/debit card make sure to fill out payment form and attach a voided check or a savings deposit slip from your account.
Health History Survey

Print Name: _________________________________________ Date: _____________________

Age: ________________ DOB: _____/_______/_______ Gender: □ Male □ Female

Name of your Primary Physician: ____________________________________ Phone: ______________________

Physician’s Address: ______________________________________________________

Please list all medications you take regularly:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

No Yes

☐ ☐ Have you ever had a stroke?

☐ ☐ Have you ever had a coronary bypass surgery or any other type of heart surgery?

☐ ☐ Do you have any other cardiovascular or pulmonary (lung) disease (other than asthma, allergies or mitral valve prolapse)?

☐ ☐ Have you ever been told by a health professional that you have an abnormal resting or stress electrocardiogram (EKG)?

☐ ☐ Have you ever experienced rapid heart action or palpitations that required medical attention?

☐ ☐ Have you ever had angina pectoris or sharp pain or heavy pressure in your chest as a result of exercise, walking or other physical activity, such as climbing a flight of stairs?

Do you have a history of: Diabetes ☐ Thyroid ☐ Kidney ☐ Liver disease ☐

If you checked any of the above questions, please describe:

________________________________________________________________________
________________________________________________________________________

Do you currently have any of the following?

No Yes

☐ ☐ Shortness of breath

☐ ☐ Unexpected dizziness or fainting

☐ ☐ Swelling of the ankles (recurrent and unrelated to injury)

☐ ☐ Heart palpitations (irregularity or racing of the heart on more than one occasion)

☐ ☐ Pain in the legs that cause you to stop walking (claudication)

☐ ☐ Known heart murmur other than mitral valve prolapse

☐ ☐ Have you discussed any of the above with your personal physician? If yes, please describe below.

________________________________________________________________________

No Yes

☐ ☐ Within the past 12 months, has a health professional told you that your blood cholesterol was greater than or equal to 240 mg/dl or that your LDL cholesterol was greater or equal to 160?

☐ ☐ Have two or more blood relatives had a heart attack or heart disease prior to age 55?

☐ ☐ Has a doctor ever recommended medication for your blood pressure or heart condition?

☐ ☐ Currently, do you have high blood pressure?

☐ ☐ Do you currently smoke cigarettes?

☐ ☐ Is there any additional health information (i.e., knee or back problems, etc.) that may be helpful to us?

________________________________________________________________________

Signature: ______________________________________ Date: ______________________

Thank you for joining The Wellness Center
Agreement and Release of Liability
For Clients 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 Regional Healthcare System and its subsidiaries and its 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 may 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 yearly or more frequent 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 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.

Print Name: ________________________________________________________________

Signature: __________________________________________________________________

Witness (Wellness Center Staff) ____________
Authorization for Release of Protected Health Information Form

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 individually identifiable health information as described above for the purpose listed. I understand that authorization is voluntary.
• I understand the notice of the Privacy 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 provider, 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: _________________________________