EMORY
DECATUR
HOSPITAL

Emory Decatur Hospital 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)***

□ Emory Employee/Department **Name:** ____________________________
□ Emory 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 Emory Decatur Wellness Center 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 Emory Decatur Wellness Center 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 Emory Decatur Wellness Center by other members and staff for any reason deemed sufficient in the sole discretion of management.

PROVISIONS: Emory Decatur Wellness Center 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. Emory Decatur Wellness Center 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 Emory Decatur Wellness Center 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 Emory Decatur Wellness Center.

DISHONORED CHECK: If any check payable to the Emory Decatur Wellness Center 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	Three Months PIF	Six Months PIF	12 Months PIF
Adult (16-59)	$75	$42	$120	$240	$456
2 Adults (16-59)	$99	$80	$234	$468	$912
Senior Adult (60+)	$50	$36	$102	$204	$384
2 Senior Adults (60+)	$75	$68	$198	$396	$768
Emp. North Decatur	N/A	$24	$72	$143	$286
Emp. Hillandale	N/A	$11	$33	$65	$130
Emp. Combo	N/A	$30	$91	$182	$364
Corporate	$50	$36	$102	$204	$384
Hospital Volunteers	N/A	$36	$102	$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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Emory Decatur Hospital Wellness Center
Health History Questionnaire

General Information

Today's Date ______________________

Member's Full Name ______________________ Date of Birth ______________________

Physician's Name ______________________ Physician's Phone Number ______________________

Section #1 Check all that apply:

- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Pacemaker/implantable cardiac defibrillator
- ☐ Heart Valve Disease
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Any other cardiovascular problems not listed on this medical history? Please specify: ______________________
- ☐ Diabetes
- ☐ Asthma or lung disease Identify: ______________________
- ☐ Currently being treated for cancer If so what type: ______________________
- ☐ History of cancer If so what type: ______________________
- ☐ Stroke
- ☐ Currently pregnant

Medications

Please list any medications you are currently taking:

____

Exercise History

On average, **how many days per week** do you exercise or do physical activity?

Days per week: ______________

On average, **how many minutes of physical activity** or exercise do you perform each of those days?

Minutes per day: ______________

Section #2 Check all that apply:

- ☐ Male ≥ 45 years
- ☐ Female ≥ 55 years, have had a hysterectomy, or are postmenopausal
- ☐ Exercise less than 3 times per week, or get less than a total of 90 minutes per week
- ☐ Current smoker or quit smoking within the previous 6 months or exposure to environmental smoke
- ☐ Have high cholesterol or on medication for (level is ≥ 200 mg/dl)
- ☐ High blood pressure
- ☐ Currently taking medication for blood pressure or heart condition
- ☐ Pain in your chest when you do physical activity
- ☐ Burning cramping sensation in your legs when walking short distances
- ☐ Close blood relative who had a heart attack, heart surgery, or stroke before age 55 (father or brother) or age 65 (mother or sister)?
- ☐ Autoimmune disease please specify: ______________________
- ☐ Vertigo
- ☐ Balance Issues
- ☐ Prone to fainting or seizures (e.g., epilepsy)
- ☐ Brain Injury Date: ______________________
- ☐ Osteoporosis/osteopenia
- ☐ Bone or joint problem that could be made worse by a change in your physical activity Please specify: ______________________
- ☐ Concerns about the safety of exercise

Please list any additional comments on your medical history:

____

Informed Health Risk

This section to be completed with a fitness staff member. Staff initials: __________ Participant signature: ______________________

☐ Yes, I have been made aware of the above health-risk factors and have been advised to see my physician prior to engaging in activity.

☐ Yes, I have been made aware of my level of health risk: ☐ Low ☐ Moderate ☐ High

Privacy Statement Data collected using this form is considered confidential and will be used exclusively in support of the program. It will not be sold or distributed to any outside companies, individuals or agencies for sales or marketing purposes.

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Emory Decatur Hospital Wellness Center
Health History Questionnaire

FITNESS ASSESSMENT PROCESS

Fitness Assessment

The purpose of a fitness assessment is to establish a fitness program based on your unique ability and needs. You will be guided through a series of tests that will assess your aerobic capacity, muscular strength, endurance, flexibility, blood pressure, heart rate, and body composition. You may stop at any time because of signs of fatigue or discomfort.

Responsibilities of the Participant

Information you have about your current health status or previous experiences of unusual feelings with effort or during the test is important. It is your responsibility to fully communicate any and all such information when completing the required forms and when meeting with the fitness testing staff.

Expected Benefits

The fitness test is performed solely for the purposes of determining safe levels of exercise and to establish a base-line to measure progress in your fitness program. The test is not a medical stress test and does not take the place of regular appointments with your physician.

Risks and Discomforts

The possibility exists of certain changes occurring during the fitness assessment. This may include changes in blood pressure, dizziness, faintness, irregular heartbeat, shortness of breath, muscular strain and in rare instances, heart attack, stroke or death. Every effort will be made to minimize these risks by reviewing the health history information and by close observation during the assessment.

Please select the appropriate box:

☐ I have read this form and I understand the assessment is voluntary, the potential risks and discomforts and consent to the herein described fitness assessment.

OR

☐ I have been made aware of the assessment offering. I have been informed of the risk factors to my health and for participating in regular physical activity at the center. I waive my participation in the fitness assessment at this time.

I give permission to provide the information obtained during the assessment to my physician/healthcare provider as indicated on my health intake information.

I understand the information obtained may be used for statistical analysis or scientific purposes with my identity being kept private. Emory Decatur Wellness Center respects your privacy and agrees not to use your personally identifiable information by taking measures to protect your information through password protections and secured hosting.

I hereby release and forever discharge and hold harmless Emory Decatur Wellness Center and its successors, assigns and third party agents from any and all liability, claims and demands of whatever kind of nature either in law or in equity, which may arise or hereafter arise from the testing described herein.

MEMBER'S NAME (PRINTED)

MEMBER'S SIGNATURE DATE

EMPLOYEE SIGNATURE DATE

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Agreement and Release of Liability

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 Emory Decatur, 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 Emory Decatur Wellness Center 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 Emory Decatur's policy that any members with disabilities shall be entitled to reasonable accommodations for their physical and mental impairments. It is also Emory Decatur 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) ____________

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Authorization for Release of Protected Health Information

Emory Decatur Wellness Center

Patient's Full Name: ____

Date of Birth: ____

Street Address: ____

Authorization for Release of Protected Health Information

I hereby authorize Emory Decatur 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 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_________________________

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Wellness Center Member Guidelines

Fitness Floor Guidelines

1. Before working out, check in at the front desk. If your membership has expired, payment is required before working out.
2. Personal Training may only be conducted by Wellness Center Staff. Please see Fitness Manager if you would like to schedule a personal trainer.
3. Members must adhere to the following Dress Code:
    a. Sweat pants, yoga pants, and athletic shorts are permitted.
    b. Shirts are required in all areas except the pool and locker rooms.
    c. No jeans or restrictive clothing.
    d. Proper athletic footwear (closed toed shoes with a closed back) is required. Sandals, flip flops, bare feet are not allowed except in the pool and locker room.
4. Be courteous to all members. Any behavior that may jeopardize the safety of others will not be allowed and may result in suspension of membership.
5. Wipe off equipment after use. Gym wipes are on fitness floor.
6. When others are waiting, limit the number of sets and time on each machine.
    a. 30 minute time limit on cardio machines.
7. Please refrain from wearing strong perfume or cologne during workout and in locker rooms.
8. All beverages must be in spill proof and non-breakable container.
9. Cell phone use on the fitness floor is prohibited. Cameras should not be used on fitness floor or in locker room.
10. Allowing non-members access to the Wellness Center without checking in at the front desk may result in suspension of membership.

Swimming Pool Guidelines

1. Please show up to class on time. If you are more than 10 minutes late, please wait until the next class begins. Please be respectful of our instructors and other members.
2. Showering is required before entering pool.
3. Only bathing suits and approved aquatic apparel are allowed in the pool.
4. Aquatic shoes are encouraged.
5. No diving, pushing, shoving, spitting, urinating or horseplay is allowed in pool.
6. Please remove all jewelry, make-up and band-aids before entering pool.
7. No walkers in lanes during lap swim. Two swimmers are allowed per lane.
    a. Lap swimming is defined as continuous movement.
8. No lap swimmers during free time.
9. No open sores, wounds or blisters in pool.

Group Fitness Guidelines

1. Please show up to class on time. If you are more than 10 minutes late, please wait until the next class begins. Please be respectful of our instructors and other members.
2. Proper attire is required for land and water group fitness classes. Please see fitness floor guidelines and swimming pool guidelines for additional information.
3. Do not use the exit door in the Group Fitness Studio or beside massage therapy except for emergencies only. Please use the exit in front of the Wellness Center Check-in desk.

I have read and understand the content, requirements, and expectations for the Emory Decatur Hospital Wellness Center. By signing I agree to abide by these guidelines.

Member Signature: _______________________________ Date: _______________