



Welcome to Huntsville Hospital Wellness Center! Below are some guidelines to help you begin your membership with us.

Membership Signup Process

Please complete paperwork and return it to the front desk. At this time, payment is required for your Assessment & Orientation and first month's dues. Please be sure to choose a payment method for your future dues. If you decided on bank draft, please provide a voided check. If you would not like payment by automatic billing, we request that dues be paid a minimum of six months at a time. Your Assessment & Orientation appointments may be made at this time and you should receive a form to have your blood drawn at our laboratory if you desire. You may begin using the facility as soon as you join!

Anytime you come to the facility, you should be in comfortable clothes, ready to work out!!

The two appointments will consist of the following:

Initial Assessment

- Test will take 30-45 minutes, testing includes measurements of strength, flexibility, cardiovascular fitness, muscle endurance, body composition and measurements, blood pressure and heart rate.
- **Wear comfortable clothing for exercising** (ex. shorts, sweats, T-shirt, athletic shoes, no footed tights or pantyhose).
- **DO NOT** exercise before your appointment.
- **DO NOT** eat a heavy meal **for four hours prior to appointment.**
- **Be well hydrated**-drink plenty of water before your appointment. No caffeinated or alcoholic beverages.

Orientation

- Appointment will take approximately 1 hour.
- Results from your Health/Lifestyle Questionnaire, blood work and fitness assessment are discussed at this time.
- Your personal exercise program is designed at this time. You will physically go through your program so dress appropriately.

Blood Work

- No appointment necessary to have blood drawn, however you must have a blood work form (available at our front desk).
- Lipid profile, total cholesterol, HDL cholesterol, cholesterol/ HDL ratio, triglycerides and glucose are measured.
- Blood work is separate from the Assessment and Orientation and should be done at least 3 days prior to your Orientation; it can be done before or after your Assessment.
- Please see blood work form for Lab location and operating hours nearest you.
- A **12 hour fast** is recommended for accurate results. You may either have water, black coffee or coffee with sweetener and any medications you are currently taking. Diabetics, please follow regular eating schedule.



Rules and Regulations

1. All members must check into the center each visit by either manually entering their member ID or by scanning key tag.
2. Memberships are non-transferable. One-Time Payment Options are not refundable.
3. Any member may be expelled by the management. Cause for expulsion may consist of any violation of the Rules and Regulations of the Center, or any conduct which in the opinion of the management is detrimental to the welfare or character of the center.
4. Membership definitions:
 - a. **Individual:** 26 years or older.
 - b. **Youth:** 12-25 years old. Applicants under 14 years old must have parent or legal guardian co-sign application. Members 12-13 years old must have parent, guardian or responsible adult supervision while in the center.
 - c. **Spouse:** Member who is legally married to another member.
 - d. **Family:** Membership for immediate family (mother, father, sons and/or daughters 12-25yo).
 - e. **Corporate:** Membership for current employees of companies with at least 3 members of center.
5. All over the counter membership fees paid will be a minimum of 6 months by cash, check, credit card, debit card or gift card, and are not refundable.
6. Leave of Absence (LOA) may be granted for medical, military, job or school issues. Member must fill out the LOA form (prior to the 20th of the month before the LOA is to start), pay a \$10 processing fee and have a current, paid in full membership. LOA's are granted for up to a 3 month basis. LOA's are not intended for non-use of facility.
7. Members who are terminating membership must present written notification prior to the 20th day of the previous month before termination. Huntsville Hospital employees who payroll deduct their dues must give 30 days written notification to allow for payroll deduction to be stopped. Within 6 months of termination, previous members may rejoin at 50% of the standard joining fees. After 6 months, rejoining will be at new member pricing.
8. All members and guests must be clothed appropriately at all times. Cut off blue jeans are not permitted. Swim suits or the like are required in the sauna, steam room, whirlpool and pool. Pool shoes are encouraged in those areas. Swim suits are not permitted in the gym or aerobic area. Closed-toed shoes must be worn to workout in the gym area.
9. Lockers are provided for member use. Members are responsible for their own personal possessions and keeping lockers locked while using the facility. Lockers are not permitted for overnight use. The center or its employees will not be responsible for items placed in lockers.
10. Showers are required prior to using the sauna, whirlpool, steam room and pool. Showers are also required after the sauna/steam room IF the member is going to the pool/whirlpool.
11. Sauna/Steam room/Whirlpool should be limited to 15 minutes of total use per member. For some members, these areas may cause undue cardiovascular stress. Elderly persons and those suffering from heart disease, diabetes, high or low blood pressure, have open wounds, infections virus or diseases, or who are pregnant should not use these areas.
12. In the event of thunder/lightning in the area, the pool/whirlpool area will be closed down until 30 minutes after the last episode of thunder/lightning.
13. Diving in the pool is prohibited. There is no lifeguard on duty and members swim at their own risk. Do not enter the pool if you have an open wound, infectious virus or disease.
14. Smoking, smokeless tobacco, alcohol or the use of non prescription drugs are strictly prohibited within the center. Food and open containers of beverages are prohibited in the gym area.
15. It is prohibited for anyone, other than an authorized law enforcement officers to bring or have in possession a weapon, explosive or other items classified by law as a weapon at the center.
16. Play care is available for the centers members and guests. Specific guidelines will be provided upon enrollment in that program.
17. The fitness equipment in this facility presents hazards which, if not avoided, could cause serious injury or death. Read warning labels and instructions. Seek assistance if you have questions. Immediately report improperly working equipment to staff. Do not attempt to repair any malfunctioning equipment.



Wellness Center

Membership Application

First: _____ MI: _____ Last: _____ Sex: () Male () Female

Address: _____ DOB: _____

City, State, Zip: _____

Phone: _____ () Home () Cell () Work Email: _____

Phone: _____ () Home () Cell () Work

Employer: _____ Referred by: _____

Emergency contact: _____ Phone: _____ Relation: _____

PAYMENT INFORMATION

() Automatic billing by **checking** (*must have voided check*)

() Automatic billing by **credit card** (*present card to staff member for entry into database*)

() **Payroll deduction** (Huntsville Hospital employees only) Employee ID: _____

I hereby authorize Huntsville Hospital Wellness Center to initiate debit entries as shown in this application. I may cancel this authorization in writing with a 30 day notice.

Applicant's signature Date

() No automatic billing (must pay **6 months** in advance) _____
**No Refunds on dues paid in advance* Applicant's signature / date



Initial

As a member of the Huntsville Hospital Wellness Center, I agree to abide by all Rules & Regulations of the Center. These rules were provided to me by the Center, and I understand it is my responsibility to read and abide by these rules.

FOR OFFICE USE ONLY:

MEMBER ID: _____

Employee Initials: _____

Today's Date: _____

Member Type: _____

Assessment/Orientation Amount: \$ _____

Date Joined: _____

Monthly Dues: \$ _____

Payment Type: _____

Prorated Amount: \$ _____ Keytag: \$ _____

Keytag Barcode #: _____

Total Paid: \$ _____

EFT start or expiration date: _____

Notes: _____

| Name: | | Height: | Weight: | DOB: |
|---|--|--|-----------|------------------|
| Yes | No | Has a doctor ever diagnosed you with a heart condition? If yes, what and when was the diagnosis? If yes, please list Cardiologist's name: | | |
| Yes | No | Has a doctor ever recommended medication for a heart condition? If yes, please list any current medications: | | |
| Yes | No | Do you have breathing problems (COPD, chronic bronchitis, symptomatic asthma)? If yes, what and when was the diagnosis? If yes, please list doctor's name: | | |
| Yes | No | Do you have a kidney, liver, or thyroid disorder? If yes, what and when was the diagnosis? If yes, please list doctor's name: | | |
| Yes | No | Has a doctor ever diagnosed you with Cancer? If yes, what and when was the diagnosis? If yes, please list Oncologist's name: | | |
| Yes | No | Do you have Diabetes? If yes, circle one: Type 1 or Type 2 How long? If yes, please list doctor's name: | | |
| Yes | No | Have you ever had a stroke or TIA (Transcient Ischemic Attack)? If yes, what and when was the diagnosis? If yes, please list doctor's name: | | |
| SECTION B | | | | |
| Yes | No | Do you have pain in your legs when walking moderate distances? | | |
| Yes | No | Do you have chest pain brought on by physical activity? | | |
| Yes | No | Have you had any problems with dizziness, fainting or seizures? If yes, circle one. | | |
| Yes | No | Do your ankles swell (edema)? | | |
| Yes | No | Do you have bone or joint problems that could be aggravated by physical activity? | | |
| Yes | No | Do you get short of breath with mild exertion? | | |
| Yes | No | Has a doctor ever recommended medication for your blood pressure? Please list meds. below. | | |
| Yes | No | Has your total cholesterol been measured at greater than 200mg/dl? Please list meds. below. | | |
| Yes | No | Has your doctor ever said that your blood sugar is too high (Fasting 100mg/dl)? List meds. below. | | |
| Yes | No | Do you have family history of heart disease in a relative younger than 55? Relation: | | |
| Yes | No | Do you use tobacco products? Which and how long? | | |
| Yes | No | Are you physically inactive on most days? | | |
| Yes | No | Are you pregnant or recently pregnant? If currently pregnant, please list OBGYN below. | | |
| Yes | No | Are you aware of any other physical reason that would prohibit you from exercising without medical supervision? | | |
| If yes to any of the above in section B, please give specifics: | | | | |
| Please list any current medications (prescriptions or over the counter): | | | | |
| Please list primary care physician's and other specialist's information (please print): | | | | |
| Name: | | Phone: | Location: | |
| Name: | | Phone: | Location: | |
| OFFICE USE ONLY | Risk Stratification: LOW or MODERATE or HIGH | | | Staff Signature: |
| | Medical Clearance Required? YES or NO | | | Date Sent: |



Program and Medical Clearance Waiver / Disclaimer for Individual Participation

_____ has enrolled in membership at the Huntsville Hospital Wellness Center. I have enrolled in this program of my own free will and hereby release and discharge Huntsville Hospital, the Wellness Center and its employees/instructors from any claims of action, suits, manner of actions and causes of actions whatsoever, for or by any reasons of any cause or matter arising out of my participation in this program, including any activities in which I may participate in that occur on the property or off the Wellness Center's property.

If member is between the ages of 12-13, I understand that he/she must be supervised by a parent/guardian while on the premises, unless he/she is participating in a Wellness Center sponsored program which provides supervision.

As a member of the Huntsville Hospital Wellness Center, I agree to abide to all Rules & Regulations of the Center. These rules were provided to me by the Center, and I understand it is my responsibility to read and abide by these rules.

I understand that if my health history indicates a need for medical clearance according to the American College of Sports Medicine, I currently wish to waive the need for medical clearance at my own risk. I shall hold the Wellness Center owners and their directors, officers and employees harmless from any and all loss, cost, claim, injury, damage and liability sustained and/or resulting from an act that I may incur from participating in any activity, service or program of the Huntsville Hospital Wellness Center.

I also authorize the Huntsville Hospital Wellness Center to use or disclose my health information to:

Physician: _____

Address: _____

Phone number: _____ **for the purpose of developing and administering my wellness programs.**

I do not have a primary care physician.

Signature of Member or Parent / Guardian

Date