Health Status Questionnaire

Membership Type_______________________

Guest Fee_______________________

Assessment Fee ☐ Yes ☐ No

General Training ☐ Yes ☐ No

Contract Expiration Date_______________________

Scan or email back to web_fit@womans.org

We require all program participants to fill out this questionnaire truthfully and completely to help us determine if you are ready to exercise and/or if you require a physician's consent to exercise. This questionnaire is in accordance to the standards of care for fitness facilities advocated by the American Heart Association and the American College of Sports Medicine.

Name (Printed)_______________________ Today's Date_______________________

Address_______________________ City_______________________ State________ Zip____________

Daytime Phone_______________ Date of Birth____________ Email Address_______________________

Emergency Contact_______________________ Phone_______________________

Primary Physician_______________________ Phone_______________________

Part One:

If you answer Yes to either #1, #2 or #3 below, we will require a physician's clearance for you to participate in the program.
This allows input from your physician.

1. Has your doctor ever told you that you have heart disease (specifically heart attack, heart bypass surgery, leg bypass surgery, congestive heart failure, and/or angina/chest pain?) ☐ Yes ☐ No
2. Has a doctor ever told you that you have diabetes? ☐ Yes ☐ No
3. Are you pregnant? ☐ Yes ☐ No

**If you answered YES to any questions in Part One,
please read and sign Physician Clearance Process below, then complete side two.**

Part Two:

If you answer YES to two or more statements below, we will require one of our fitness staff to review your responses and determine if a physician's clearance is required. If you do not know the answers to some of these questions, the fitness staff will go over this with you.

☐ Yes ☐ No **You are older than 55, or have had a hysterectomy or are postmenopausal.**

☐ Yes ☐ No **You smoke or quit smoking within the past six months.**

☐ Yes ☐ No **Your blood pressure is greater than 140/90 mmHg.**

☐ Yes ☐ No **Your blood cholesterol is greater than 200 mg/dl.**

☐ Yes ☐ No **You have a close blood male relative (father or brother) who had a heart attack or heart surgery before the age of 55 or a close female relative (mother or sister) who had a heart attack or surgery before the age of 65.**

☐ Yes ☐ No **You are physically inactive (you get less than 30 minutes of physical activity at least 3 times per week).**

☐ Yes ☐ No **Your waist circumference is greater than 35 inches.**

Medical Clearance needed per Fitness Staff (Signature):_______________________ **Date:**_______________

Fitness Staff Clearance (Signature):_______________________ **Date:**_______________

Physician Clearance Process:

If you are required to have a physician's consent, you can choose one of the following **(circle):**

1. We will fax the form on your behalf and contact you when we receive it.
2. We will provide you with the form to mail or fax to your physician.

Participant approval for clearance_______________________ Date:_______________

Part Three:

Answers to these questions below, may indicate you need a physician's clearance and are eligible for shorter term memberships or programs with increased supervision.

Do you have?

1. A rheumatoid condition, such as arthritis or fibromylgia, that limits your ability to exercise (excluding osteoarthritis)?
   ☐ Yes ☐ No Describe:________________
2. A joint, back or neck injury that significantly limits your ability to exercise?
   ☐ Yes ☐ No Describe:________________
3. A respiratory diagnosis that significantly limits your ability to exercise?
   ☐ Yes ☐ No Describe:________________
4. Have you ever had a joint replacement? ☐ Yes ☐ No
   If yes, what joint(s) were replaced and when?________________
5. Have you ever had a stroke (including TIA)? ☐ Yes ☐ No
   If yes, when?________________
6. Have you ever had a spinal cord injury? ☐ Yes ☐ No
   If yes, when?________________
7. Do you have a diagnosed neurological condition? ☐ Yes ☐ No
   Describe:________________
8. Do you have balance problems that limit your ability to exercise? ☐ Yes ☐ No
9. Do you have a history of falling? ☐ Yes ☐ No
10. Do you use any assistive devices for walking or moving? ☐ Yes ☐ No
    ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other________________
11. Do you currently have (or have had in the past 12 months) a bone, joint, or soft tissue (muscle, ligament or tendon) problem that could be made worse with physical activity? ☐ Yes ☐ No
    PLEASE LIST CONDITIONS________________
12. Do you have any mental health problems or learning difficulties? *(Alzheimers, Dementia, Depressions, Anxiety Disorder, Phychotic Disorder, Intellectual Disability, Down Syndrome)* ☐ Yes ☐ No
    PLEASE LIST CONDITIONS________________

Referred to Clinical Staff ☐ Yes ☐ No Date of referral:________________

__________ **I have read, understood and completed the above questionnaire. Any questions I had were answered to my full satisfaction.**
Initials

Agreement and Release of Liability

__________ Initials

In consideration of gaining membership or being allowed to participate in the activities and programs of Woman's Center for Wellness and to use its facilities, and equipment, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge the Woman's Center for Wellness 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 my use of equipment in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of the Woman's Center for Wellness or the use of any equipment at the Fitness Club.

__________ Initials

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 used equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

__________ Initials

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 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 my physician's permission to participate, or that I have decided to participate in activity and/or use of equipment without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment in my activities.

Signature ________________ **Date**________________

Staff Witness________________

Health History

The Health History form is designed to help identify individuals for whom physical activity might be inappropriate at the present time or recommend an appropriate exercise program. It is not intended to substitute for a complete physical examination and assessment by a physician. It is recommended that each client discuss exercise with a physician prior to initiation of an exercise program. With this understanding, please answer the following questions accordingly.

Last Name ________________ First Name ________________ Middle Initial ________

Address ____

Email Address ____

Home Phone ________________ Work Phone ________________ Alternate Phone ________________

Marital Status: Single Married Divorced Widowed Gender: Male Female

Spouse's Name ________________ Phone ________________

Emergency Contact ________________ Phone ________________

Primary Physician ________________ Phone ________________

MEDICAL AND LIFESTYLE HISTORY

Instructions

Complete each question accurately. All information provided is confidential. In most cases, please check mark the correct answers. Only check those that apply.

1. Do you have a history of the following conditions, **medically diagnosed** by a physician or a healthcare professional? *Check all that apply.*

☐ Abnormal EKG or Chest x-ray	☐ Bronchitis, Chronic	☐ Cancer	☐ Hip Problems
☐ Cigarette Smoking	☐ Other Lung Disorders	☐ Hearing Loss	☐ Back Problems
☐ High Blood Pressure	☐ Anemia, blood disorder	☐ Vision Loss	☐ Shoulder Problems
☐ High Cholesterol	☐ Liver Disorder	☐ Mental Illness	☐ Neck Problems
☐ Diabetes	☐ Thyroid Disorder	☐ Osteoporosis	☐ Recent Broken Bones
☐ Peripheral Vascular Disease	☐ Kidney Disorders	☐ Osteopenia	☐ Swollen or Painful Joints
☐ Heart Attack or Stroke	☐ Hypoglycemia	☐ Urine Leakage	☐ Major Injury
☐ Irregular Heart Beat or Rhythm	☐ Eating Disorders	☐ Chronic Headaches	☐ Balance Problems
☐ Heart Condition	☐ Gout	☐ Phlebitis or Blood Clot	☐ History of Falling
☐ Heart Murmur	☐ Epilepsy or Seizures	☐ Congenital Defect	☐ Other ________
☐ Stroke	☐ Arthritis	☐ Rheumatic Fever	________
☐ Emphysema	☐ Fibromyalgia	☐ Foot Problems	________
☐ Asthma	☐ Hernia	☐ Knee Problems	

Has a doctor given you any activity restrictions? ☐ No ☐ Yes **If Yes, please describe:** ________________

____

2. ☐ Yes ☐ No Do you currently have an illness or infection? ________________
3. ☐ Yes ☐ No Have you been hospitalized or had major surgery within the last year?
4. ☐ Yes ☐ No Are you pregnant or have you given birth within the last two months?
5. What operations have you had? Check all that apply and indicate date of operation.

☐ Back ______ ☐ Eyes ______ ☐ Heart ______ ☐ Hysterectomy ______ ☐ Lung ______ ☐ Other ______

☐ Ears ______ ☐ Joint ______ ☐ Hernia ______ ☐ Kidney ____ ☐ Neck ______ ______

6. Have you experienced any of the following symptoms **during exercise or activity** (including walking, climbing, stairs, or working)?
   - ☐ Chest Pain, Heaviness or Tightness
   - ☐ Extreme Breathlessness
   - ☐ Rapid Heartbeats or Palpitations
   - ☐ Shoulder or Arm Pain/Numbness
   - ☐ Dizziness or Light-headedness
   - ☐ Mental Confusion
   - ☐ Low Back or Neck Pain
   - ☐ Leg Pain or Cramping (claudication)
   - ☐ Please Explain______________________________

7. Please select any medication or supplements you are currently using:
   - ☐ Diuretics
   - ☐ Beta Blockers
   - ☐ Vasodilators
   - ☐ Alpha Blockers
   - ☐ Other Cardiovascular Drugs
   - ☐ Blood Thinners, Aspirin
   - ☐ Nitroglycerin
   - ☐ Cholesterol
   - ☐ Calcium Channel Blockers
   - ☐ Diabetes / Insulin
   - ☐ Chemotherapy/Radiation
   - ☐ Antidepressants
   - ☐ Herbs or Supplements
   - ☐ NSAIDS / Anti-inflammatory (Motrin® /Advil®)
   - ☐ Pain Medication
   - ☐ Other Drugs____________________________

8. Please list the specific medication names that you are currently taking:______________________________

9. On average, how many times are you physically active per week?________________________

10. How long has it been since you last exercised regularly (2 – 3x per week)?____________________

11. On average, how long do you exercise per session?______________________________

12. On a scale from 1 to 10, how intensely do you exercise?__________________________

    Very Easily 1 2 3 4 5 6 7 8 9 10 *Very Intensely*

13. Which of the following activities do you like to do?
    - ☐ Running / Jogging
    - ☐ Walking
    - ☐ Stair Climbing / Eliptical
    - ☐ Bicycle / Spinning
    - ☐ Strength Training
    - ☐ Aerobic Classes
    - ☐ Swimming
    - ☐ Dancing
    - ☐ Yoga / Martial Arts
    - ☐ Golfing
    - ☐ Gardening / Yard Work
    - ☐ Bowling
    - ☐ Rollerblading or Skating
    - ☐ Other____________________

14. ☐ Yes ☐ No Do you currently smoke? How long have you smoked?________________________

    How long has it been since you quit?______________________________

15. ☐ Yes ☐ No Do you drink caffeinated beverages? How much caffeine do you drink?__________________

    ☐ Yes ☐ No Do you drink alcoholic beverages? How many drinks per week?__________________

16. Please rate your daily average stress level.
    - ☐ Low
    - ☐ Moderate
    - ☐ High: I enjoy the challenge
    - ☐ High: sometimes difficult to handle
    - ☐ High: often difficult to handle

17. Please indicate any other medical conditions or activity restrictions that you may have that are not previously mentioned. *It is important that this information be as accurate and complete as possible.*

____

____

I have read, understood and completed this questionnaire. I acknowledge, to the best of my ability, that I have answered the above questions completely and honestly. Any questions I had were answered to my full satisfaction.

Client Signature	Date	Staff Signature	Date
Personal Representative's Signature	Date	Personal Representative's Relationship to Client	

9637 Jefferson Highway
Baton Rouge, LA 70809
P 225-924-8300 • F 225-927-6951

Member Policies

The following polices apply to all members of the Fitness Center at Woman's Center for Wellness and constitute an integral part of the Membership Agreement.

MEMBERSHIP FREEZE POLICIES

Freezing your membership means that you will not be required to pay dues for a specified period of time. In summary, members are able to freeze their membership under two conditions: medical and extended travel. In both cases, members will need to verify the reason and fill out a freeze form.

- Putting your membership on freeze extends the expiration date of your membership contract.
- A freeze does not apply to situations in which the Wellness Center must be closed due to loss of power or other circumstances out of our control.

Under NO circumstances are freezes retroactive ____ (initial)

Key Points (initial required):
Medical freezes require a physician statement and a freeze form and no freeze fee is required if these steps are completed. ____ (initial). If you are medically unable to use the center, you can request a medical freeze for up to three (3) months and up to nine (9) months for a pregnancy and up to an additional two (2) months post delivery or until released by your physician.
You must provide a doctor's letter at the time of requesting a medical freeze. After the freeze period, membership will be automatically reactivated and your obligation to pay dues will resume. If an extension is needed, you will have the option of canceling your membership and receiving a refund of 90% of your unused dues. ____ (initial)

Extended travel freezes of a minimum of one month and maximum of three consecutive months require a completed freeze form and a fee of $25.00 per month for travel.
I understand I will need to make a payment in advance ($25 per month). ____ (initial)

Freeze forms must be filled out and turned in at the service desk by the **15th of the month** in order to freeze for the following month. A freeze period may be for a minimum of one month and a maximum of three months per calendar year (excluding unforeseen accidents or emergencies). Any freezes that extend beyond three months will result in a refund of 90% of the unused dues.
I understand that I must fill out a freeze form for medical and/or travel freezes. ____ (initial)

The membership expiration date will be extended for the length of time the membership was frozen. ____ (initial)

CANCELLATION POLICIES

CONSUMER'S RIGHT TO CANCELLATION: YOU MAY CANCEL THIS CONTRACT WITHOUT ANY PENALTY OR FURTHER OBLIGATION WITHIN THREE (3) DAYS FROM THE AGREEMENT DATE. Notice of cancellation shall be in writing signed by the member and mailed by registered or certified United States mail to the Fitness Center at the address specified in such form. The contract forms, membership card(s), and any other documents of evidence of membership previously delivered to the member shall accompany such notice. All monies paid pursuant to such contract shall be refunded within thirty (30) business days of receipt of such notice of cancellation.

CANCELLATION PRIOR TO CONTRACT EXPIRATION

A membership can be cancelled within a current contract only if:

• You move your residence more than 30 miles from the Wellness Center. You must provide satisfactory proof of new residence: online Post Office verification of change of address, etc. Statements from a bank or financial institution will not be accepted.
• Member has incurred a medical disability. Doctor's letter identifying disability is required.

Note: *As an option to cancellation, a membership may be transferred for a fee of $150.00 to a family member or friend. Initiation Fees are non-refundable. See below for more information about transferring membership.*

CANCELLATION FOR TERMINATION OF EMPLOYMENT **For Woman's Hospital Employees Only**

This agreement becomes null and void immediately if you or your spouse terminates employment with Woman's Hospital.

ADDITIONAL RIGHTS TO CANCELLATION

During the initial contract period, the membership contract may also be cancelled as described below:

1) If upon a doctor's order, you are physically unable to utilize the Center's services for a period in excess of six months.
2) If you die, your estate shall be relieved of any further obligation for payment of dues under the contract. If membership is prepaid, member's estate will be entitled to a 90% prorated refund beyond the 15 days required notice of cancellation.
3) If all services of the Fitness Center permanently cease to be offered as stated in the contract, all monies, except initiation fee, paid in for advance dues pursuant to such contract shall be refunded; provided however, that the Fitness Center may retain the expenses incurred and the portion of the total price representing the services used or completed, and further provided that the Fitness Center may demand the reasonable cost of goods and services which the member has consumed or wishes to retain after cancellation of the contract. In no instance shall the Fitness Center demand more than the full contract price from the member.
4) If member receives any free months as an inducement to enter into this agreement or as a result of referring new members, such free months shall not be considered in computing the amount of any refund to which Member shall be entitled.
5) If member renews late (up to 30 days after the contract expiration date), member will pay a $25 late fee.
6) If member renews 30 days or later after their expiration date, member will pay a full initiation package and the new member rates.
7) Member may cancel contract at any time for any reason not stated above for a fee of $250.
8) Your membership agreement may be transferred, with consent of management, providing that the member terminating is current, fully paid-up and has no fees due to the Center. A transfer fee of $150 will be charged. New members will recieve an assessment and training.
9) All EFT drafted and payroll deducted memberships automatically renew upon the expiration date unless a cancellation form or written notice is received fifteen (15) days prior to the expiration date. Cancellation via phone, fax or email will <u>NOT</u> be accepted.

OTHER POLICIES OF WOMAN'S CENTER FOR WELLNESS

1. WOMAN'S CENTER FOR WELLNESS RESERVES THE RIGHT TO REFUSE ADMITTANCE TO ANY MEMBER. IF MEMBERSHIP IS REVOKED, ANY REMAINING DUES WILL BE PRORATED AND A REFUND WILL BE ISSUED.

2. MEMBER'S HEALTH WARRANTY Member represents that she is in good health and has no disability, impairment, injury, disease or ailment preventing her from engaging in active or passive exercise or which would cause increased risk or injury or adverse health consequences as a result of exercise. Member assumes full responsibility for her use of the facility and shall indemnify Woman's Hospital, the owner of the Fitness Center the member is utilizing, its affiliates, agents and employees against any and all liability arising out of use of the facilities. Members with mobility, gait or cognitive issues may have restricted use of equipment.

3. RULES, REGULATIONS, AND SCHEDULES Member agrees to abide by all the membership rules, regulations and schedules of the Fitness Center, which may be posted at the Fitness Center or issued orally, and which may be amended from time to time, at management's sole discretion. There is no lifeguard on duty in the pool areas - swim and/or exercise at your own risk.

4. FITNESS CENTER FEES The Fitness Center may adjust fees for registration, programs, and services rendered at any time.

5. FITNESS CENTER DUES Membership dues can be paid through one of the following methods: bank draft (ACH debit), credit card, savings, prepay, or payroll deduction for Woman's Hospital employees and their spouses. By selecting the draft method, the buyer authorizes the Fitness Center to request payment from his/her financial institution for dues and other authorized charges. The monthly installments will be drafted on the **2nd – 8th** of every month. The member also acknowledges that dues will be drafted while contract is active regardless of member's use of the Fitness Center. By selecting the prepay method member will make payment in full via personal check, credit card or cash. By selecting payroll deduction, as an employee (spouse) of Woman's Hospital, member will make biweekly payroll deductions for the term of membership. This option is available to all full-time and part-time employees. Contract employees are not eligible for this option.

6. UNAVOIDABLE DOWN TIME No refunds or credit shall be allowed or due for time when the Woman's Center for Wellness is temporarily not available to clients and members due to repairs, loss of power, damage to the building or other dangerous physical conditions of the facility that were caused by storm, flooding, accident or other acts of God. If the entire Wellness Center is unavailable for one month or longer, no dues will be charged.

7. FITNESS CENTER REPAIRS The Fitness Center reserves the right to establish opening and closing times and to close portions of the facility on a temporary basis for repairs, maintenance and/or improvements. The Fitness Center will make every attempt to minimize these occurrences and supply alternatives whenever possible. Advance notice of such occurrences will be given whenever possible. No refunds or credits shall be given when portions of the facility are temporarily closed for repairs.

8. PRESENTATION OF MEMBERSHIP CARD No one will be admitted to the Fitness Center without displaying a valid membership card or registering as a guest. We will require a member to purchase a new card if she fails to display her card (3) three times within a 30-day period. A $6.00 fee will be assessed to replace a membership card.

9. GUESTS Member's guests are permitted in the center, but only pursuant to such rules, regulations, fees, schedules for such guest as may then be in effect. Guest does not have to be accompanied by a member. The Fitness Center reserves the right to limit the number of times any one guest can use the Fitness Center and reserves the right to exclude any guest whose use of the facility, in the sole opinion of the Fitness Center, would be detrimental to the Fitness Center or any of its members. All guests must register at the front desk. For guest policy details, refer to the Fitness Center brochure.

10. MEMBER OBLIGATIONS Member shall not be relieved of his/her obligations to make payments agreed to, and no reduction in the amount of dues shall be made because of Member's failure to use the Fitness Center's facilities. (Member dues are for the contract period and are no way related to actual usage of the Fitness Center).

11. ENTIRE AGREEMENT The membership agreement and these member policies constitute the entire and exclusive agreement between the parties and will supersede any oral or written understanding. This contract only may be modified in a writing executed by a duly authorized representative of Woman's Center for Wellness Fitness Center. Employees are not authorized to make any independent agreement with any member.

12. VALUABLES AND PERSONAL PROPERTY Members are urged to avoid bringing valuables onto center premises. Woman's Center for Wellness Fitness Center shall not be liable for the loss, theft of, or damage to, any personal property of members or guests.

13. LOCKERS The Fitness Center will only provide day lockers as a member amenity. Any items left overnight will be removed. Overnight lockers may be available for a $50 deposit to be refunded when locker key is returned plus fees of $10 per month. See service desk for details.

14. DRESS CODE Proper athletic attire is required. When in the fitness area everyone must be fully clothed. T-shirts, tank tops, sweatshirts, shorts, or pants must be worn when using the equipment. No street clothes or dress shoes permitted in fitness areas. Standard tennis shoes are required. Bathing suits must be securely worn in the pools, whirlpool and sauna. Pool shoes are recommended for all wet areas. **Please respect the modesty of other members in the locker room.**

15. BEHAVIOR No swearing, yelling, or obscene gestures will be tolerated. Racial discrimination is unacceptable. Any form of bullying or harassment will not be tolerated. Disruptive behavior such as extensive or loud phone conversations that disturb another's workout are unacceptable.

16. PHOTOS Photography is strictly prohibited in the locker and shower areas. Photos may only be taken of self or at the request of a staff member.

17. PERSONAL TRAINING Use of non-Fitness Center personal trainers in the center is prohibited as deemed necessary by the Fitness Staff. Members may not conduct personal training of other members. Members must give 24 hours notice if they wish to cancel a personal training appointment or they will be charged.

18. UPDATED MEDICAL CONDITION If you have a change in your medical condition that could affect your ability to exercise, you may be required to get medical clearance from your physician, as deemed necessary by fitness staff. Examples include but are not limited to : pregnancy, hospitalization, cardiac/respiratory issues, bone or joint injuries, physical therapy, etc.

19. IF MEMBER HAS A CHANGE OF PAYMENT METHOD for drafted accounts, home/billing address, email address and/or phone numbers, it is the member's responsibility to inform Woman's Center for Wellness.

Congratulations on becoming a member of the Fitness Center at Woman's Center for Wellness!

I (Member) have read and agreed to these policies ____

Member Representative ____

Promotion: ___________________________

Membership # :_________________________ ☐ New

☐ Renewal: If member renews after the contract expiration date, member will be assessed a $25 late fee.

☐ Former Member: If member renews 30 days after the contract expiration date, the member will pay a full initial package and the new member rates.

MEMBERSHIP INFORMATION

Member's Name:____ Date of Birth: ______________________

Mailing Address: ____________________________ City: __________________ State:______ Zip Code: ______________

Home #___________________________ Work #____________________________ Cell #____________________________

Email Address:____

Emergency Contact Name: ____ Phone:__________________________

How did you hear about the Fitness Club? (Please list up to 2 sources)

1. ____

2.____

If you were referred by a current member, please print their name here so we can give them a gift.

____

AUTHORIZATION FOR DRAFT

I hereby authorize Woman's Center for Wellness to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my ☐ Checking ☐ Credit Card ☐ Savings Account indicated below and the depository named below to credit and/or debit the same to such account. This authorization shall remain in effect until I cancel my membership in conformance with the Center's cancellation guidelines. (Attach voided check or a copy of credit card to draft).

Signature:____ **Date**________________________

AUTHORIZATION FOR PAYROLL DEDUCTION

By selecting the payroll deduction, as an employee (spouse) of Woman's Hospital, I am agreeing to biweekly payroll deductions for the term of my membership. This agreement is for the term of my membership and can not be cancelled except for reasons noted in the Center's cancellation policy. This agreement becomes null and void if my spouse or I terminate employment with Woman's Hospital.

Name (Print):____ Spouse's Name:_____________________________________

Signature:____ Spouse's Signature:__________________________________

Employee #:_______________________Date________________ First Deduction Date:__________ Last Deduction Date:__________

Terms and conditions of membership to the Club as they are represented on this contract and in the Fitness Club Member Policies Sheet that are contained or referenced are considered a part of this agreement. If any provision of this agreement, or portion thereof, is determined to be invalid or unenforceable, the provision is deemed severable from the remainder of the agreement and shall not cause the invalidity or unenforceability of the remainder of this agreement.

I acknowledge that, except for what is written in these agreements, the Club has not made any promises, representations or warranties to me. By affixing my signature below, I acknowledge and agree to the terms and conditions set forth in this agreement. In exchange, the Club grants me the right and the privilege to use the Club's facilities in accordance with the terms of this Agreement.

All EFT drafted and payroll deducted memberships will automatically renew upon the expiration date unless a cancellation form or written notice is received fifteen (15) days prior to the expiration date. We cannot cancel via phone, fax or email. __________(Initials)

I have received a copy of Member Policies. __________(Initials)

Member Signature____ **Date**________________________

Club Representative____ Date________________________

OFFICE USE ONLY

TYPE OF MEMBERSHIP: ☐ General Fitness ☐ Club 55 ☐ Club 62 ☐ Teacher ☐ Student ☐ Medical ☐ Other

TERM OF MEMBERSHIP: ☐ 6 months ☐ 12 months ☐ _____ months **Contract Begins:**________ **Contract Ends:**________

TYPE OF PAYMENT: ☐ Bank Draft (ACH Debit) ☐ Prepay ☐ Payroll Deduction for Woman's Hospital employees

BANK DRAFT

Monthly Dues Rate:	$___________
Less______ Discount:	$___________
Subtotal:	$___________
Plus LA Sales Tax	$___________
Total Monthly Payment:	$___________

PREPAY

Total_____Monthly Dues	$ ___________
Less______ Discount:	$ ___________
Subtotal:	$ ___________
Plus LA Sales Tax	$ ___________
Total Amount Due:	$ ___________

PAYROLL DEDUCTION

Total____Monthly Dues	$ ___________
Less______ Discount:	$ ___________
Subtotal:	$ ___________
Plus LA Sales Tax	$ ___________
Total	$ ___________
Total Per Pay Period	$ ___________
Number of Pay Periods	___________

FEES/PACKAGES

Initiation Package	$ _________
Firestarter Package/Type__________________	
Add Towel Fee	$ _________
Add Playroom Fee	$ _________
Add Locker Fee	$ _________
Total Fees	$ _________

TOWEL FEE ($5/month)

Prepay	$_________
Bank Draft	$_________
Payroll	$_________

PLAYROOM FEES

$5.00 per Child

Total # of children________

Total $_________________

PAYMENT DUE AT JOINING

Total Fees	$ _________
Pro-rated Dues for___________	$ _________
Prepaid Dues for_____________	$ _________
Subtotal	$ _________
Plus LA Sales Tax	$ _________
Firestarter Package/Type______________________	
Nutrition	$120
Personal Training	$120
Other	$120
Total Payment Due at Joining	$ _________

PAYMENT METHOD

☐ Check#_________ ☐ Cash

☐ Mastercard ☐ VISA ☐ Discover ☐ Amer. Exp.

☐ Other

COMMENTS:______________

____

____