Owensboro Health Healthpark

For Office Use Only
- ❒ Regular
- ❒ Exercise is Medicine
- ❒ Corporate
- ❒ GoldenFit
- ❒ Other:_____

REJOIN: ❒ YES ❒ NO

Member Application

❒ Primary Member

Please Print

_____ _____
Applicant Birth Date

_____ _____
Home Address Phone

_____ _____
City State Zip Email Address

_____
Business/Employer

How did you hear about the Healthpark? ❒ Family/Friend ❒ Physician ❒ Healthpark Member
❒ Hospital/Clinic ❒ Newspaper ❒ Internet/ Social Media ❒ Live/Work Nearby

❒ Associate Member

Primary Member:_____

_____ _____
Applicant Birth Date

_____ _____
Phone Email Address

Business Employer:_____

❒ Eligible Family Member(s) defined as legal dependents who are at least 13 years old and less than 26 years old. (If joining)

Primary Member:_____

Name _____ Relationship _____ Birth Date _____

Name _____ Relationship _____ Birth Date _____

Name _____ Relationship _____ Birth Date _____

Name _____ Relationship _____ Birth Date _____

_____ **I acknowledge that I have received the Healthpark Member Guidelines.I understand that failure to abide by these Guidelines can result in suspension or termination of my Membership at Healthpark's sole discretion.**

Signature of Applicant _____ **Date:**_____

Accepted by _____ **Date:**_____

Owensboro Health Healthpark

Member
Pre Participation Screening Form

Last Name | First Name | Mid. Initial | Sex M/F

_____/_____/_____ | _____ | _____

Date of Birth | Phone # | Email

_____

Emergency Contact Name and Phone Number

A.) 1.___YES ___NO Do you have any signs or symptoms of cardiovascular, metabolic, or kidney diseases, such as the following:

___Chest pain or tightness - pain radiating down through jaw, neck, or arm
___Shortness of breath with mild exertion or at rest
___Dizziness, fainting or difficulty with balance
___Ankle swelling
___Heart palpitations or tachycardia (fast heart rate - over 100 beats/min at rest)
___Cramping pain in the legs while exercising
___Discomfort with breathing while lying down
___Unusual fatigue or shortness of breath when performing daily activities

2. ___YES ___NO Are you currently NOT exercising regularly, AND have diagnosed cardiovascular, metabolic, or kidney diseases, such as the following

___Heart/cardiovascular disease
___Peripheral vascular disease
___Stroke or cerebrovascular disease
___Elevated blood sugar
___Kidney disease

If you answer YES to question 1 or 2 it is required that you get a physician's clearance in order to have a personalized exercise prescription. Further, it is strongly recommended that you get a physician's clearance to participate in any Healthpark fitness program.

B.) Exchange of Medical Information

I authorize the exchange of any relevant medical or health related information between the Healthpark and the physician designated. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith had already occurred in reliance of this consent.

Signature: _____ Date: _____

C.) Acknowledgement of Privacy Practice for Healthpark receipt

I have read, understood and completed this questionnaire to the best of my ability, and as accurately and completely as possible. Any questions that I had were answered to my full satisfaction. This information is confidential and only intended for use by the appropriate employees at the Healthpark.

Signature: _____ Date: _____

Accepted by: _____ Date: _____

Fitness Assessment (please ✓ and initial)

I ____decline ____accept the opportunity to participate in a fitness assessment and equipment orientation based on personalized exercise prescription. Initial_____

Staff Use Only

Fitness Assessment Appt: _____/_____/_____ @ _____ a.m./p.m.

ID Checked_____ Team Member_____ Today's Date_____

OwensboroHealth
Healthpark

WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

1. Healthpark offers individuals the opportunity to improve their health and fitness through a variety of activities in individual, self-directed, group or personal trainer sessions. These activities include, but are not limited to, aerobic exercise, strength training, flexibility techniques, use of weight and exercise equipment and machinery, massage therapy, participation in the Micro Fit Health and Fitness Assessment Program ("MicroFit"), and many other special fitness events or activities on and off the Healthpark campus (collectively referred to as "Healthpark Activities").

2. A physician's approval is strongly recommended before any participation in Healthpark Activities and yearly or more frequent physical examinations and consultations with a physician are recommended when continuing participation in Healthpark Activities. I and, if applicable, my child, have either had a physical exam and have been given a physician's approval to participate or that I have decided to participate and, if applicable, to allow my child to participate, in Healthpark Activities without the approval of a physician. I am, and, if applicable, my child is, physically sound and suffering from no condition that would prevent me or my child from participation in Healthpark Activities. If I or, if applicable, my child, suffer from any condition that requires regular consultation with or treatment by a physician, or if I or, if applicable, my child have recently undergone any invasive medical procedure (such as surgery), I agree to consult with a physician before I or my child engage in any Healthpark Activities. Furthermore, in order to receive a personalized exercise prescription, individuals who are at risk for cardiovascular, metabolic, or kidney diseases as noted on the Pre Participation Screening Form are required to have physician's clearance.

3. I acknowledge the contagious nature of COVID-19 and other diseases, and I voluntarily assume the risk that I or, if applicable, my child may be exposed. I understand such exposure could result in quarantine, serious illness, disability, and/or death. Healthpark has put in place reasonable steps to slow the transmission of COVID-19; however, I understand that Healthpark cannot guarantee I or, if applicable, my child will not become infected. Further, participating in Healthpark Activities could increase the risk of contracting COVID-19. I or, if applicable, my child shall follow all Healthpark rules, which may change, including but not limited to the following:

- regularly and thoroughly cleaning hands with an alcohol-based hand rub or washing them with soap and water, avoiding touching face, and covering mouth/nose when coughing or sneezing.
- wiping down equipment and regularly touched surfaces.
- not visiting the Healthpark or participating in Health and Fitness Improvement Activities if:
    - sick or experience symptoms of COVID-19, including, without limitation, fever, cough or shortness of breath,
    - have a suspected or diagnosed/confirmed case of COVID-19 or another communicable illness, or
    - have been recently exposed to any person who has a suspected or confirmed case of COVID-19.
- masking and social distancing when appropriate.

4. Participation in Healthpark Activities involves inherent dangers and an exposure to a greater risk of disease or personal injury than if one chooses not to participate, despite the use of reasonable care to eliminate or minimize such dangers. Injury from participation in Healthpark Activities may be minor or moderate (such as soreness, bruising, muscle fatigue, aches and pains from overuse, etc.) to serious (such as severe sprains, broken bones, pulled muscles or ligaments, etc.), or may include permanent disability and/or death, particularly when an individual suffers from an underlying physical, medical or mental health impairment or infirmity. These types of injuries may result from actions or inactions of the participant or others, or a combination of both. I acknowledge and assume the risk of injury or death to me and, if applicable, to my child, resulting from participation in any and all Healthpark Activities.

5. Healthpark has a right to deny me, my guest or my child, in its sole discretion, the opportunity to participate in, or to terminate such participation in, any Healthpark Activities at any time it appears that me, my guest or my

[continued on next page]

child are not following Healthpark rules or are exposing ourselves, others or the property of Healthpark to excessive risk.

6. In consideration for being allowed to participate in Healthpark Activities, in addition to any fee or charge, **I WAIVE, RELEASE AND FOREVER DISCHARGE HEALTHPARK, THE CORPORATION THAT OWNS HEALTHPARK, ANY AFFILIATED COMPANIES, AND ANY OF THEIR RESPECTIVE OFFICERS, DIRECTORS, AGENTS, CONTRACTORS, AND EMPLOYEES (THE "RELEASED PARTIES") FROM ANY AND ALL CLAIMS, DEMANDS, LOSSES, INJURIES, DAMAGES, ACTIONS OR CAUSES OF ACTION FOR PERSONAL OR BODILY INJURY OR PROPERTY DAMAGE (THE "CLAIMS") RELATED TO THE PARTICIPATION OF ME, MY GUEST, OR, IF APPLICABLE, MY CHILD, IN HEALTHPARK ACTIVITIES, WHETHER OR NOT THE CLAIMS ARE CAUSED BY THE RELEASED PARTIES.** In case of an accident causing injury to me or my child, during any Healthpark Activities, I agree to have me or, if applicable, my child, medically examined by a licensed physician at my sole expense and to authorize such physician to provide the written results of such examination to Healthpark and the corporation owning Healthpark. **(Please initial)** _____

7. Healthpark shall not be responsible or liable to me or my guests for property lost, damaged or stolen. I shall be liable for any damages I, my child or my guest, cause to Healthpark property, excluding normal wear and tear, and for any personal injury or property damage I, my child or my guest, cause any other member or guest, or to their property. I SHALL INDEMNIFY, SAVE AND HOLD HARMLESS the Heathpark and the Released Parties, for any loss I, my guest or my child cause for which Healthpark is accused or held liable, including reasonable attorneys' fees.

8. Each term and provision of this Waiver is intended to be severable. If any term or provision of this Waiver is determined by a court of competent jurisdiction to be illegal, invalid or unenforceable for any reason whatsoever, such provision shall be stricken from this Waiver and shall not affect the legality, validity or enforceability of the remainder of this Waiver. The laws of the Commonwealth of Kentucky shall apply to the interpretation and enforcement of this Agreement.

I HAVE READ THIS WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT AND AGREE TO ITS TERMS BY SIGNING BELOW WHERE INDICATED. If this is a family membership and a member of my family is a minor (under age 18), I represent that I am the parent or legal guardian of said minor and that I have authority to sign this Agreement on the minor child's behalf.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

Print Name of Member or Guest under age 18:_____ Date of Birth: _____

_____

Signature of Parent or Legal Guardian of Member/Guest (Circle one) Date: _____

Print Name of Parent or Legal Guardian:_____

Name of Healthpark employee who witnessed signing of this document: _____

THERE MUST BE A SEPARATELY SIGNED WAIVER ON FILE FOR EACH INDIVIDUAL USING THE HEALTHPARK.

Owensboro Health
Healthpark
1006 Ford Avenue • Owensboro, KY
688-LIFE (5433)

Health and Fitness Center
Enrollment and Monthly Charge Authorization

1. The Monthly membership plan is a continuous membership plan. This authority is to remain in full force and effect until the Health and Fitness Center has received written notice from me of termination or until the Health and Fitness Center has provided me ten (10) days prior written notice of their termination of this agreement.
2. The Board of Directors of Owensboro Health may at any time adjust the monthly rate applicable to my category of membership. I understand that I will receive thirty (30) days prior notice of any such change.
3. Should my membership charge not be honored by my bank or credit card company for any reason, I understand that I am responsible for said payment plus a $25 service charge in addition to any bank service fee(s).
4. I hereby authorize Owensboro Health to charge the bank account or credit card account for my initial and monthly membership payments. Such charge will be assessed on the 5th day of each month during the term of membership.
5. I understand it is my responsibility to review my bank or credit card statement promptly to verify the accuracy of any charges imposed by Owensboro Health.
6. Requests for refunds or credits due as a result of errors must be made to the Business Services Office within 60 days of my receipt of my bank or credit card statement, but in no event more than 90 days after the charge is assessed. Any charges not contested within this period are deemed to be correct and will not be subject to refund.
7. I understand that if I wish to terminate or change my membership in any way, **I must provide the Membership Services Office with written notice thirty days before the date of the automatic monthly charge date, which is the 5th day of the month I wish to terminate. For example, if I want to terminate effective in May, notice must be received by Owensboro Health on or before April 5th.** Cancellation forms are available at the front desk. I further understand that I must turn in all membership cards upon termination of my membership.
8. I understand that the enrollment fee is nonrefundable after three (3) days.
9. Members may freeze their memberships for a maximum of three calendar months per year for medical reasons or if you will be out of town. $18.00 per month will be deducted for each member while on freeze. Freeze forms are available at the front desk and must be filled out prior to the month you wish to freeze. At the expiration of the freeze period, charges for the full amount of the monthly membership fee will resume. Any member wishing to discontinue monthly payments must terminate membership completely and incur enrollment fees that may be in effect when membership is resumed.

ENROLLMENT AND MONTHLY DUES

Member Name _____
Associate Member Name _____
Additional Family _____
_____

Enrollment Fee_____
Monthly Dues_____

ENROLLMENT FEE PAYMENT ⑦ Check ⑦ Credit Card ⑦ Cash

MONTHLY DUES AUTOMATIC CHARGE ⑦ Checking ⑦ Credit Card

Credit Card Type: ⑦ Mastercard ⑦ VISA ⑦ American Express ⑦ Discover

Credit Card Number _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____

Credit Card Expiration Date _____

OR

Checking Account Number _____

Bank Routing Number _____/_____/_____/_____/_____/_____/_____/_____/_____

Bank Name _____

I certify that I have read the above 9 points and fully agree to the terms and conditions of the agreement.

Signature _____ **Date** _____