Ascension Saint Thomas

WELLNESS CENTER

1840 Medical Center Parkway Suite 203
Murfreesboro, TN 37129
Phone: 615-396-5500 / Fax: 615-396-6189
healthcare.ascension.org

## Membership Application

Name _____ Date of Birth _____ Age _____ Gender (M/F) _____

Home Address / City / State / Zip Code _____ Email Address _____

Place of Employment _____ Work Number _____ Home Number _____ Cell Number _____

Emergency Contact Name / Relationship _____ Emergency Contact Number _____

## Type of Membership / Payment (staff fill in information between dotted lines)

☐Community
☐Hospital employee
☐Contract employee ☐Touchpoint
☐CR/PR graduate
☐Silversneakers ☐Prime Fitness
☐Silver & Fit
☐Optum
☐Other

**Start date:** _____

☐Prorated payment for 1st month: $_____ ➢ cash credit card check

☐Bank draft monthly payment:$_____

☐Membership paid in full $_____ ➢ cash credit card check

☐Other/Notes_____

## Payment and Fee Policy Agreement

All monthly payments are collected through automatic bank draft between the *2nd and 5th* of each month. You will NOT receive a monthly bill. Fees are subject to change. Membership can be terminated at any time by submitting a written notice before the 1st of month.

As a new member of Ascension Saint Thomas Rutherford Hospital Wellness Center, I have read and understand the above policies and agree to the terms listed.

Membership signature: _____ Print name:_____ Date: _____

Staff signature: _____Date: _____

Staff Use Only- Physician Release Needed: ☐Yes ☐No; Physician Release Received: ☐Yes ☐No
Notes:_____
_____Staff Initial:_____Date _____

## Exercise Evaluation

Please fill out the goals section ***IF*** you are interested in scheduling an appointment with an Exercise Physiologist. This appointment is ***free of charge*** and will include an individualized exercise prescription.

☐Yes interested ☐No thanks ☐Maybe later

## Goals

1. Are you interested in weight loss/gain? How much? _____
2. Are you interested in strength training? _____
3. Please list specific goals or needs: _____
   _____
4. Health concerns or restrictions? _____
   _____
   _____

**Schedule** (staff fill in information between dotted lines)

First appointment Date/Time:_____EP on schedule: _____

B/P_____ Resting HR_____ Notes _____

## Agreement and Release of Liability

I hereby request permission to participate in the activities and programs available at the Ascension Saint Thomas Rutherford Hospital Wellness Center and to use its facilities and equipment in exchange for an agreed payment. I acknowledge receiving and reading a copy of the Ascension Saint Thomas Health Wellness Center by-laws relating to the operation and use of its facilities, published by Ascension Saint Thomas Health and its agents. I understand that my failure to observe the by-laws may result in my exclusion from the premises.

I declare myself to be physically able to use the equipment and facilities provided. I understand that before I use the Wellness Center facilities and exercise equipment I can choose to schedule an individualized exercise assessment designed by the Wellness Center staff. I understand and agree that by using the facilities provided there is the possibility of physical injury or even death. I also understand that the use of the facilities and exercise equipment may be unsupervised. I hereby agree to assume and accept all risks of injury or death. I further agree to identify and release Ascension Saint Thomas Rutherford Hospital, its officers, agents, employees, representatives, executors, and all others from all responsibilities or liability for injuries or damages resulting from my participation at the Wellness Center.

I further declare myself personally responsible for any financial cost incurred due to transportation and medical expenses as a result of any injury incurred. Ascension Saint Thomas Rutherford Hospital Wellness Center assumes no responsibility or liability for lost, misplaced, stolen and or damaged personal property.

I have answered all questions truthfully and have read this entire Agreement and Release of Liability and agree to all of its terms and conditions effective immediately.

I understand that the Wellness Center will keep my wellness and medical records only as long as I remain a current member. I understand that my records will be destroyed when I choose to cease my membership.

Member Signature:_____ Date:_____

## Pre-Exercise Screening Questionnaire

*This participation screening form was developed for exercise professionals for use with ACSM's preparticipation screening algorithm, which can be found in ACSM's Guidelines for Exercise Testing and Prescription, 10th edition, 2018.*

## Step 1: SYMPTOMS

Do you experience:
_____ chest discomfort with exertion
_____ unreasonable breathlessness
_____ dizziness, fainting, blackouts
_____ ankle swelling
_____ unpleasant awareness of a forceful,rapid or irregular heart rate
_____ burning or cramping sensations in your lower legs when walking short distances

If you **did** mark any of these statements under symptoms, **STOP** exercise and seek medical clearance before engaging in or resuming exercise.
If you **did not** mark any questions, continue to Step 2 and 3.

## Step 2: CURRENT ACTIVITY

Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the last 3 months?
☐Yes ☐No

## Step 3: MEDICAL CONDITIONS

Have you had or currently have:
_____ a heart attack
_____ heart surgery, cardiac catheterization, or coronary angioplasty
_____ pacemaker/implantable cardiac defibrillator/rhythm disturbance
_____ heart valve disease
_____ heart failure
_____ heart transplantation
_____ diabetes
_____ renal disease

## Evaluating Steps 2 and 3

• If you did NOT mark any of the statements in Step 3, medical clearance is not necessary.
• If you marked Step 2 "yes" and marked any of the statements in Step 3, you may continue to exercise at light to moderate intensity without medical clearance. Medical clearance is recommended before engaging in vigorous exercise.
• If you marked Step 2 "no" and marked any of the statements in Step 3, medical clearance is required. It is also recommended you use a facility with medically qualified staff, such the Wellness Center.

## Personal Information

Physicians Name:_____Physicians Number/Fax_____
Current Medications:_____

Members Signature**:**_____Print Name:_____Date:_____