HAMILTON HEALTHCARE SYSTEM
WELLNESS CENTER

Membership Application

All Questions MUST Be Completed, PLEASE PRINT

Health Spa Operator Registration Number 20110007

Name: _____ _____ ___ Date of Birth: ____/____/____
Last First M.I.

Sex: Male Female Age: ____(All persons applying for membership must be 16 years of age or older.)

Home Address: _____ Home Phone: _____
_____ Work Phone: _____
_____,TX _____ Employer: _____
City Zip Occupation: _____

In case of Emergency, Whom Should We Contact?
Please print, so we may obtain this information quickly during an emergency.

Name: _____
Relationship: _____
Phone Number: (_____) _____-_____

Your Physician's (M.D.) Name: _____
(If not local please provide phone number.) (_____) _____ - _____

Initial Below:
_____ By initialing, I indicate that I have read and completely answered the above membership questions.

PLEASE COMPLETE PAGE 2 ON THE OTHER SIDE.

FOR OFFICE USE ONLY

- **Current Height: _____.**
- **Current Weight: _____.**
- **BMI (Body Mass Index): _____.**
- **Blood Pressure: _____.**

_____.
Personal Trainer Signature

HAMILTON HEALTHCARE SYSTEM
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YOUR PERSONAL MEDICAL HISTORY

Please Circle the appropriate response. All questions must be answered.

If you answer yes to any of the questions listed below, a medical clearance from your physician (M.D.) prior to becoming a member and exercising at the Hamilton Wellness Center is required.

No Yes 1.	Has your doctor ever said that you have any type of heart trouble?
No Yes 2.	Have you had pains in your heart and/or chest area during the past six months?
No Yes 3.	During the past six months, have you had any spells of severe dizziness or have you felt faint?
No Yes 4.	Has a doctor ever said your blood pressure was "too high", regardless of current medications?
No Yes 5.	Has a doctor ever said you have any form of diabetes?
No Yes 6.	Has your doctor ever told you that you have a bone or joint problem of any type?
No Yes 7.	Do you have arthritis or osteoporosis?
No Yes 8.	Have you ever had any type of knee surgery?
No Yes 9.	Have you ever had any type of hip surgery?
No Yes 10.	Have you ever had any type of shoulder surgery?
No Yes 11.	Have you ever had any type of back and/or neck surgery?
No Yes 12.	Has your doctor ever told you that you have asthma, chronic bronchitis, emphysema, or COPD?
No Yes 13.	Have you had any surgical procedures during the past 12 months that could possibly limit your range of motion or limit your involvement in any type of physical activity?
No Yes 14.	Has your doctor ever told you to limit the amount of weight that you lift?
No Yes 15.	Has your doctor ever given you any physical limits in respect to exercise?
No Yes 16.	Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
No Yes 17.	If you are over the age of 65, are you accustomed to vigorous exercise?
No Yes 18.	(Females) Are you currently pregnant?

Initial_____I have read and completed the above Personal Medical History. It is true and correct, and all questions have been answered.

Please read the following statement before signing:

All exercise and participation is done at the risk of the member or his/her guest. The Hamilton Wellness Center and its management are not liable for personal injury. By signing this application, the member understands and agrees that he/she waives his/her rights and the rights of his/her heirs, administrators, executors, successors and assigns to all claims arising out of the use of the premises and the membership including but not limited to personal injury, including bodily injury and death, and all property damage.

Signature: _____ Date: _____/_____/_____

By signing this application, I indicate that I have read the above and fully understand and agree to the terms of this application and all my questions have been answered fully.

HAMILTON HEALTHCARE SYSTEM
WELLNESS CENTER

MEMBERSHIP AGREEMENT

This agreement is between the Hamilton Wellness Center of the Hamilton County Hospital District (hereinafter Center), and _____ (hereinafter Member).

In consideration of the terms and conditions stated below, the parties agree and obligate themselves as follows:

A. The member agrees to abide by the policies of the Center as they now exist and as they may be amended.

B. For use of the Center facilities, the member(s) agrees to pay the Center a non-refundable and non-transferable activation fee of $_____, and monthly dues fitting the selected membership category. The member agrees that if this membership is terminated without notice, or if this membership is terminated prior to twelve months from the date of this agreement, or if this membership is terminated due to non-payment of an out-standing account balance with the Center, this application fee or fees are not eligible to be used at a later period toward re-application for membership in the Center.

C. **IND JT FAM SENIND SENJT HLT TRIAL EMP EMPJT CORP** If a Joint or Family membership is marked, the member acknowledges that all family members included in this membership are sixteen years of age or older and are legal dependents or the spouse of the member signing this agreement and are correctly listed on the reverse of this agreement, unless otherwise authorized in writing by a member of the Center's management. This membership category gives the member and family members (as described above) full access to the Centers programs and its facilities. The Member also acknowledges that he/she is 18 years of age or older. The Center reserves the right to close portions of the Center or programs due to maintenance or lack of use without prior notice.

D. **MONTHLY QUARTERLY SEMI-ANNUAL ANNUAL EFT** The dues payable each month are $_____. Upon joining, the member's monthly dues for the first month will be assessed on a prorated basis after the 10th day of the month. All services and goods that are electronically transferred (EFT) will be drafted by the 15th of each month. A **$25 NON-PAYMENT FEE** will be added to all accounts and a thirty (30) day suspension of the member's usage of the facility if the bank account is rejected. The full amount owed must be paid during the suspension period or the membership will be terminated. Statements for month-to-month accounts are sent out on the 1st of each month. A **$10 LATE FEE** will be added to all accounts and suspension of the member's usage of the facility if payments are not received by the 20th of the month. **Prepaid memberships will automatically convert to a (30) day suspension period during which time the member is responsible for unpaid balances and future membership fees**. **(*Member Initial*) _____.** Balances for services or goods not paid within thirty (30) days may be forwarded to a collection agency.

E. A completed application is required for membership, and in some cases, a physician's signature may be necessary. Any misrepresentation on the member's application may result in immediate termination of the individual membership or family member if appropriate.

F. The effective date of the agreement shall be the ____day of _____, 20__ and will continue until written notification is received from the member as described in section G.

G. **A MEMBER IS REQUIRED TO PROVIDE THIRTY (30) DAYS NOTIFICATION OF INTENTION TO CANCEL A MEMBERSHIP. THE EFFECTIVE DATE OF THE NOTIFICATION IS THE DATE THE NOTIFICATION IS RECEIVED IN THE CENTER'S OFFICE.** THE MEMBER IS RESPONSIBLE FOR DUES AND FEES INCURRED DURING THE MEMBERSHIP PERIOD.

H. **THE MEMBER UNDERSTANDS THAT UPON TERMINATION OR CANCELLATION, THE STANDARD ACTIVATION FEES AND ANY UNPAID BALANCES ARE TO BE PAID IN FULL PRIOR TO RENEWING THE MEMBERSHIP**.

I. The Center RESERVES THE RIGHT TO ADJUST THE MONTHLY DUES RATES AND STRUCTURE WITH THIRTY (30) DAYS WRITTEN NOTIFICATION TO THE MEMBERSHIP. After the notification date, the member will have thirty days to cancel or downgrade the membership without penalties or fees.

J. The member acknowledges that member's use of the facilities and equipment is at member's own risk of any bodily injury, illness, death, or property damage. Member hereby releases, waives, forever discharges, and covenants not to sue the Center or the Hamilton County Hospital District dba Hamilton Wellness Center, or any agents, servants, or employees of the Center or the Hamilton County Hospital District dba Hamilton Wellness Center for any and all loss and damage or any claim or demands of any type, known, on account of or in any way related to any illness, condition, or injury to member or member's property or which may result in member's death. Member expressly acknowledges that member understands the paragraph to be a waiver and release of the Center and the Hamilton County Hospital District dba Hamilton Wellness Center and the agents, servants, and employees of the Center and the Hamilton County Hospital District dba Hamilton Wellness Center from any liability for injury or harm incurred while involved in the use of equipment or facilities or while engaging in any activity at the Center.

K. Misuse of the Center's facilities and/or equipment and/or irresponsible actions by the member, as judged by the Center's personnel, may result in immediate termination of the membership with no refund or payments.

L. **THE MEMBER ACKNOWLEDGES THAT THE CENTER IS NOT A FEE-FOR-SERVICE BUSINESS AND DUES ARE TO BE PAID REGARDLESS OF CENTER USAGE.** The membership monthly fees can be suspended without a cancellation of the membership, due to medical reasons with written notification by a physician.

M. This agreement is not assignable by either party to any other person.

N. Member and Center acknowledge this Agreement contains the entire agreement and the Center makes no warranties of representation, expressed or implied, other than those set forth herein. The terms of this agreement are enforceable in a court of law. If any portion of this agreement is held to be invalid or unenforceable, such portion shall be disregarded and the remainder of this agreement shall remain in full force and effect.

Witnessed and signed this _____ day of _____, 20___

_____

Member's Signature

(By signing, the member acknowledges that he or she has read and fully understands the above agreement and all questions have been answered.)

_____

Authorized Signature (Center Staff Member)

Revised: July 2010

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FAMILY DEPENDENT MEMBERSHIP SECTION

I, _____, verify that the following individual(s) (hereafter known as "Family member") is to be included in my family membership. I also agree to pay the non-refundable application fee for each family member who meets the family membership qualifications for full usage of the Center's facilities.

I verify that the family member or members listed below meet all the qualifications listed below for inclusion in my family membership.

Family Membership Qualifications:

All persons to be included in the family membership are legal dependents (as described by the IRS) between the ages of sixteen years and twenty-five years and/or a legal spouse living at the same address of the responsible member of the contract.

Family Member Rights and Privileges:

All family members receive FULL usage of all the Center's facilities and programs. Legal dependents under the age of sixteen are allowed to utilize specific areas and programs while the parent or guardian is in the Center, unless otherwise specified. There is not an application fee for dependents under the age of sixteen.

List All Family Members That Will Utilize The Center's Facilities Under This Membership (Please Print)

1. _____Birth Date:____/____/____

   Relationship:_____ Activation Fee: $ _____ Member Initial _____

2. _____Birth Date:____/____/____

   Relationship:_____ Activation Fee: $ _____ Member Initial _____

3. _____Birth Date:____/____/____

   Relationship:_____ Activation Fee: $ _____ Member Initial _____

4. _____Birth Date:____/____/____

   Relationship:_____ Activation Fee: $ _____ Member Initial _____

5. _____Birth Date:____/____/____

   Relationship:_____ Activation Fee: $ _____ Member Initial _____

The member agrees to provide written notification to the management of the Wellness Center in the event of any changes in the status of the family member or members listed above. The member agrees to provide this written notification within (30) days of the change in the family member's status. In the event that a family member is found to no longer meet the family membership qualifications listed above, the family member will be removed from the family membership. All family members are to follow all rules and regulations of the Center as outlined in the "membership agreement" section of this contract and follow any directions provided by the staff of the Center.

Witnessed and signed this _____ day of _____, 20___

_____

Member's Signature (By signing, the member acknowledges that he or she has read and fully understands the above agreement and all questions have been answered.)

_____

Authorized Signature (Center Staff Member)

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Acknowledgement of Receipt of Membership Information

I have been provided with a Member Information Notice that provides a more completed description of the rules and regulations of the Wellness Center Facility. I understand that I have the right to review the notice prior to signing a Membership Agreement. I understand that the organization reserves the right to change their Notice and practices, and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes.

By signing this form, I consent to the user and disclosure of protected personal and health information about me for the purpose of payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

_____
(Member's Name PRINTED)

_____ _____
(Member's SIGNATURE) DATE

_____ _____
(Wellness Center Staff Signature) DATE