Lifestyle Medicine & Fitness Center

UW Medicine | VALLEY MEDICAL CENTER

POWERED BY PINNACLE MEDICAL WELLNESS

Valley Fitness Center
New Member Enrollment

DEMOGRAPHIC INFORMATION

Full Name [Last, First, MI] _____ Today's Date_____

Date of Birth _____ Gender: ☐ Male ☐ Female

Phone _____ Email _____

Street Address [street, city, zip code] _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____Phone _____

Enrollment Category

- ☐ Community
- ☐ Golden Care
- ☐ Family Add On [proof of residence required] Primary Member: _____

Classification, Dues & Fees

A. For access to Valley Fitness Center Facilities, the member agrees to pay a non-refundable/non-transferrable Enrollment Fee of:

☐ **Community Membership**:	$75/+tax	☐ **Lifestyle 365 Enrollment:**	$149/+tax
☐ **Family Add On**:	$37.50/+tax	☐ **VMC Volunteers**:	$0
☐ **Corporate Affiliate**:	$37.50/+tax	☐ **Rehabilitation Completion**:	$0

B. Monthly dues are billed by the **5th of each month** through Automatic Bank Draft, Automatic Debit/Credit Card Payment or VMC Payroll Deduction. The member agrees to pay monthly dues to maintain their membership:

Community Membership

☐ **Individual**:	$51.50/+tax
☐ **Golden Care**:	$46.50/+tax
☐ **Affiliate**:	$41.50/+tax
☐ **Family Add On**:	$36.50/+tax
☐ **Volunteer:**	$30/+tax

Prescriptive Membership

☐ **Individual:**	$90.50/+tax
☐ **GoldenCare**:	$85.50/+tax
☐ **Affiliate**:	$85.50/+tax
☐ **Family Add On:**	$75.50/+tax
☐ **Volunteer**:	$69+tax

Payment Options

C. I authorize my bank to pay and to charge my account the amount of any automatic bank or credit card withdrawal plan drawn on my account made payable to Valley Medical Center. Payment will take place between the first [1st] and tenth [10th] day of the month the fees are due. I understand that this authorization will remain in effect until revoked by me in writing. *Initial*: _____

☐ **Automatic Payment by Credit/Debit Card** ☐ **Automatic Payment by ACH Bank Draft**

Membership Agreement

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

Eligibility

D. Individuals eighteen [18] years of age or older may apply for VFC membership subject to current rules and guidelines. *Initial*: _____

E. **Medical Clearance** by a physician may be required per the Medical Screening Guidelines of VFC. Membership may be denied based on contraindications or health concerns for exercise. *Initial*: _____

Rights & Privileges

F. Membership with VFC does not grant or bestow upon any member any right of ownership or interest equity. *Initial*: _____

G. Membership grants the use of VFC facilities as they are made available under conditions established by VFC Management and UW Valley Medical Center Administration for the mutual enjoyment of all its members and guests. *Initial*: _____

H. Non- VMC Corporate Members are not authorized to enter VFC Facilities prior to standard operating hours. *Initial*: _____

I. The member agrees to abide by the policies, guidelines and rules of VFC as they now exist and as they may be amended. UW Valley Medical Center is solely responsible for all interpretations, enforcement and additions to these rules. *Initial*: _____

J. Memberships and membership cards are non-transferrable. Anyone caught allowing a non-member to use their membership will face revocation of their membership. *Initial*: _____

K. VFC will send monthly electronic communication to all members for scheduling and updates. I authorize the use of my email address for this purpose. *Initial*: _____

L. VFC Management and Valley Medical Center Administration reserve the right to terminate any membership due to non-compliance of facility policies. *Initial*: _____

Accounts

M. Accounts not paid in full by **the 5th of the month** will incur a **$25 late fee**, including any payments denied or checks returned for insufficient funds. *Initial*: _____

N. Delinquent accounts for 60 days or more will automatically be terminated. The member is responsible for all delinquent charges and dues. *Initial*: _____

O. A re-enrollment fee will be charged to re-activate a terminated membership, in addition to any delinquent charges. *Initial*: _____

P. Family Memberships apply to individuals who reside in the **same household** [*proof of residence required*]. _____ is the primary member on the account and is financially responsible for all members of the account. If at any time, the primary member is no longer an active paying member or refuses to pay for a family member, the family member will convert to an individual member and is responsible for the increase in enrollment and dues. *Initial*: _____

Membership Processing

Q. **Changes:** A member is required to provide written notification by the 25th of the month is he/she intends to change the status of his/her membership. *Initial*: _____

R. Cancellations: Upon written notification and return of VFC membership card, the membership cancellations will be effective the first [1st] day of the following month. There are no refunds for any portion of the month in which VFC receives notice of cancellation. Cancelled Annual Memberships will be refunded the prorated amount of the annual dues, equal to the number of months remaining under the agreement, starting on the 1st day of the following month. *Initial*: _____

S. Medical Holds: Medical Holds with written verification from the member's physician can be accommodated at no charge for up to six [6] months. A Medical Clearance is required from the member's physician for membership re-activation. Membership charges, and automatic payments, will resume at the end of the 6-month period. *Initial*: _____

T. **Basic Holds:** Full paying members are eligible to place their membership on a hold for up to six months, once per year, with a paid processing fee of **$10 for one [1] month or $50 for two to six [2-6] months**.
Membership privileges will be suspended beginning the 1st day of the following month. Membership charges will resume the month following advanced notice of request (see change request guidelines). Membership charges, and automatic payment agreements, will resume at the end of the hold period. *Initial*: _____

U. **Guest Policy:** Members may bring a guest up to three [3] times per year, for a fee of $10/visit. *Initial*: _____

Liability Release & Waiver

By signing below, I, _____ acknowledge the policies of Valley Fitness Center and understand that my membership may be revoked for failure to abide by policies & procedures as set forth by the management of Valley Fitness Center and UW Valley Medical Center. I agree to release and hold harmless King County Public Hospital District #1 [DBA Valley Medical Center]. Its officers, directors, employees and agents, from all liability for claims or damages that may arise from my participation in the Fitness Center, including but not limited to, personal injury of any kind.

_____

Printed Name **Signature** **Date**

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Physical Activity Readiness Questionnaire [PAR-Q]

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for **most** people. This questionnaire will indicate if it is necessary for you to seek advice from your physician or a qualified medical professional before becoming more physically active.

General Health Questions

Please circle Yes or No

1. Has your doctor ever diagnosed you with have a heart condition or hypertension? Yes No
2. Do you feel pain in your chest during rest, activities of daily living or when active? Yes No
3. Within the past year, have you lost consciousness or lost your balance due to dizziness? Yes No
4. Have you been diagnosed with a chronic medical condition, other than hypertension or heart disease?

   Please List Conditions Here: _____ Yes No
5. Within the past year, have you had any orthopedic conditions that could be made worse

   with physical activity? Yes No
6. Has your doctor ever indicated that you should perform only medically supervised activity? Yes No
7. Are you taking prescribed medication for a chronic medical condition? Yes No
8. Please list medications and conditions in the space below.

*If you answered **NO** to all the questions on this page, you are cleared for physical activity*

*If you answered **YES** to any of the questions on this page, please complete the questions on the next page*

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Follow Up Questions: *Please circle Yes or No*

1. Do you have Arthritis, Osteoporosis, or a Back Condition that is not controlled with physician prescribed therapies? Yes No
2. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? Yes No
3. Are you currently undergoing cancer treatment such as chemotherapy or radiation? Yes No
4. Do you have a Heart or Cardiovascular condition such as CAD, Heart Failure or A-Fib that is not controlled with physician prescribed therapies? Yes No
5. Do you have Chronic Heart Failure? Yes No
6. Do you have diagnosed cardiovascular disease and have not participated in regular physical activity in the past 60 days? Yes No
7. If you have hypertension, is it currently not managed with physician-prescribed therapies? Yes No
8. Do you have a resting blood pressure equal or greater than 160/90mmHG with or without medication? Yes No
9. Do you have a metabolic condition such as Pre-Diabetes, Type I Diabetes or Type II Diabetes that is not controlled nutritionally or with physician-prescribed therapies? Yes No
10. Do you have any Mental Health Problems that you are having difficulty controlling with physician-prescribed therapies? Yes No
11. Do you have a respiratory disease such as COPD or Asthma that is not controlled by physician-prescribed therapies? Yes No
12. Have you had a Stroke that causes impairment in mobility? Yes No
13. Do you have any other medical conditions not listed above, such as kidney disease, epilepsy, a head injury or neurological problems? Yes No

*If you answered **NO** to all the follow-up questions about your health, you are ready to become more physically active*
*If you answered **YES** to one or more of the follow up questions about your health, please complete the Medical Clearance Form on the next page. Valley Fitness Center requires a Medical Clearance from your physician prior to enrollment*

Participant Declaration
I have read, understood and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes.
I also acknowledge that Valley Medical Center will retain this form for their records.

Signature Date