

Healthy You Fitness Center: Who Can Join?

- LVHN employee
- LVHN employee's family
- LVHN physician
- LVHN physician's family
- LVHN volunteer
- LVHN patient
- LVHN clinical program participant
- LVHN wellness program participant
- Cedar Crest Professional Park employee
- Health Works client employee

Are you currently being treated by a physician for a medical condition?

- YES – May I ask what condition you are being treated for? (See list below)
- NO – Send or fax *Physician Referral and Clearance for Exercise* form

Chronic Diseases and Disabilities

- | | | | |
|---|---|---|--|
| <input type="radio"/> Abdominal Organ Transplant | <input type="radio"/> Brain Injury | <input type="radio"/> End Stage Metabolic Disease | <input type="radio"/> Obesity |
| <input type="radio"/> AIDS | <input type="radio"/> Cancer | <input type="radio"/> Epilepsy | <input type="radio"/> Orthopedic |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Cardiac Transplant | <input type="radio"/> Fibromyalgia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Amyotrophic Lateral Sclerosis | <input type="radio"/> Cerebral Palsy | <input type="radio"/> Frailty | <input type="radio"/> Pacemaker |
| <input type="radio"/> Anemia | <input type="radio"/> Chronic Fatigue Syndrome | <input type="radio"/> Hyperlipidemia | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Aneurysms | <input type="radio"/> Chronic Heart Failure | <input type="radio"/> Hypertension | <input type="radio"/> Peripheral Arterial Disease |
| <input type="radio"/> Angina and Silent Ischemia | <input type="radio"/> Chronic Obstructive Pulmonary Disease | <input type="radio"/> Lower Back Pain Syndrome | <input type="radio"/> Polio and Post-Polio Syndrome |
| <input type="radio"/> Arthritis | <input type="radio"/> Chronic Restrictive Pulmonary Disease | <input type="radio"/> Lower-Limb Amputation | <input type="radio"/> Spinal Cord Dis-Paraplegia and Tetraplegia |
| <input type="radio"/> Asthma | <input type="radio"/> Childhood Obesity | <input type="radio"/> Lung and Heart Transplant | <input type="radio"/> Stress |
| <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Coronary Artery Bypass Graft | <input type="radio"/> Mental Illness | <input type="radio"/> Stroke |
| <input type="radio"/> Bleeding and Clotting Disorders | <input type="radio"/> Cystic Fibrosis | <input type="radio"/> Mental Retardation | <input type="radio"/> Valvular Heart Disease |
| | <input type="radio"/> Deaf and Hearing Impaired | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Visual Impairment |
| | <input type="radio"/> Diabetes | <input type="radio"/> Muscular Dystrophy | <input type="radio"/> Other _____ |
| | | <input type="radio"/> Myocardial Infarction | _____ |

Non-Member Fitness Assessment (\$125)

Locations

Healthy You Fitness Center–Cedar Crest
 1243 S. Cedar Crest Boulevard, Lower Level
 Allentown, PA 18103
 Phone: 610-402-3699
 Fax: 610-402-3690

Healthy You Fitness Center–Muhlenberg
 1770 Bathgate Road, Third Floor
 Bethlehem, PA 18017
 Phone: 484-884-2851
 Fax: 484-884-2917

Healthy You Fitness Center–Mack
 2100 Mack Boulevard, Second Floor
 Allentown, PA 18013
 Phone: 484-884-0780
 Fax: 610-402-3690

Physician Referral and Clearance for Exercise

Patient Information

PATIENT NAME _____ DOB _____

HOME PHONE _____ CELL PHONE _____

Physician Information and Referral

PHYSICIAN NAME (PRINT) _____ PHONE NUMBER _____

Reason for Referral

- | | | | | | |
|---|---|---|---|---|--|
| <input type="radio"/> Abdominal Organ Transplant | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Chronic Restrictive Pulmonary Disease | <input type="radio"/> Epilepsy | <input type="radio"/> Mental Illness | <input type="radio"/> Peripheral Arterial Disease |
| <input type="radio"/> AIDS | <input type="radio"/> Bleeding and Clotting Disorders | <input type="radio"/> Childhood Obesity | <input type="radio"/> Fibromyalgia | <input type="radio"/> Mental Retardation | <input type="radio"/> Polio and Post-Polio Syndrome |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Brain Injury | <input type="radio"/> Coronary Artery Bypass Graft | <input type="radio"/> Frailty | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Spinal Cord Dis-Paraplegia and Tetraplegia |
| <input type="radio"/> Amyotrophic Lateral Sclerosis | <input type="radio"/> Cancer | <input type="radio"/> Cystic Fibrosis | <input type="radio"/> Hyperlipidemia | <input type="radio"/> Muscular Dystrophy | <input type="radio"/> Stress |
| <input type="radio"/> Anemia | <input type="radio"/> Cardiac Transplant | <input type="radio"/> Deaf and Hearing Impaired | <input type="radio"/> Hypertension | <input type="radio"/> Myocardial Infarction | <input type="radio"/> Stroke |
| <input type="radio"/> Aneurysms | <input type="radio"/> Cerebral Palsy | <input type="radio"/> Diabetes | <input type="radio"/> Lower Back Pain Syndrome | <input type="radio"/> Obesity | <input type="radio"/> Valvular Heart Disease |
| <input type="radio"/> Angina and Silent Ischemia | <input type="radio"/> Chronic Fatigue Syndrome | <input type="radio"/> End Stage Metabolic Disease | <input type="radio"/> Lower-Limb Amputation | <input type="radio"/> Orthopedic | <input type="radio"/> Visual Impairment |
| <input type="radio"/> Arthritis | <input type="radio"/> Chronic Heart Failure | | <input type="radio"/> Lung and Heart Transplant | <input type="radio"/> Osteoporosis | |
| <input type="radio"/> Asthma | <input type="radio"/> Chronic Obstructive Pulmonary Disease | | | <input type="radio"/> Pacemakers | |
| <input type="radio"/> Other _____ | | | | <input type="radio"/> Parkinson's Disease | |

Physician Clearance

_____ Patient is cleared to participate in submaximal graded exercise testing and exercise programming at the Healthy You Fitness Center.

Additional medical concerns or restrictions to exercise programming: _____

_____ Patient must have diagnostic stress test prior to exercise.

Physician's Signature

Date

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General Fitness Assessment

Description

The General Fitness Assessment is a measure of your overall level of fitness. It is not intended as a formal "stress test" as used to diagnose heart disease. Although college-degreed American College of Sports Medicine Certified Health Fitness Instructors and/or National Strength and Conditioning Association-Certified Strength and Conditioning Specialists

supervise the test, there is not a physician in attendance. We therefore, strongly recommend that all persons over 45 years of age have had a medical examination within the last year.

If you have any concerns about your health or suffer from any of the following disorders, have your physician fill out the medical clearance below.

Participant Exercise Readiness Questionnaire

- | YES | NO | |
|-------|-------|---|
| _____ | _____ | 1. Has a doctor ever said that you have a heart condition? |
| _____ | _____ | 2. Do you experience pain in your chest/heart during rest or activity? |
| _____ | _____ | 3. Has a doctor ever said that your blood pressure is too high? |
| _____ | _____ | 4. Do you ever become dizzy or lose consciousness? |
| _____ | _____ | 5. Do you have any bone or joint problems that could be aggravated by exercise? |
| _____ | _____ | 6. Do you experience shortness of breath with mild exertion or have general difficulty breathing? |
| _____ | _____ | 7. Are you currently taking any medication for a heart condition, blood pressure, diabetes or cholesterol? |
| _____ | _____ | 8. Do you smoke, or have you quit in the last 6 months? |
| _____ | _____ | 9. Are you over 45 years of age? |
| _____ | _____ | 10. Are you not accustomed to regular exercise (i.e. at least 30 minutes of exercise a minimum of 3 days per week for at least 3 months)? |

Personal Data

NAME _____ DATE _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE _____ CELL PHONE _____ BIRTH DATE _____ AGE _____

E-MAIL ADDRESS _____

Medical History

YES NO

- _____ 1. Is there a medical or other condition limiting your exercise performance?
 _____ 2. Are you presently taking medication? List below along with reason

Lifestyle History

1. How do you describe the stress in your life? Slight Moderate High
 2. How do you best describe your lifestyle? Physically active Sedentary

Exercise History

1. What are your primary health/fitness objectives and goals? (Check where indicated)
 Improve your overall health Weight reduction Improve muscle strength
 Improve sport skills Improve flexibility Other _____
2. Where do you plan to exercise? Fitness Center Home Travel Other _____
3. How much time is available for you to exercise? (ex: 30 min./session, 4 sessions/week)
 _____ minutes/session _____ sessions per week
4. What sports or recreational activities do you currently participate in? (list)

5. Check your exercise preferences
 Walk Jog Run Swim Bike Racquet sports Golf
 Weight training Calisthenics Exercise classes Other _____
6. List your dislikes: _____
7. What problems did you previously have in exercising?

Fitness Assessment Preparation Guidelines

1. Bring a list of all of the medications, supplements, eye, ear or nose drops or sprays, medical problems and past or planned surgeries.
2. Get adequate sleep the evening before your fitness assessment.
3. Wear comfortable clothes such as shorts or lightweight gym warm-up pants, T-shirt, exercise bra (women), socks, athletic shoes.
4. Take your usual medications as prescribed by your physician.
5. Refrain from vigorous physical activity 24 hours prior to testing.
6. Refrain from eating 3 hours prior to testing.
7. Refrain from tobacco use, alcohol, caffeine or flavored beverages 3 hours prior to testing.
8. Drink plenty of water during the 24 hours prior to testing. Bring a plastic bottle of water for testing and exercise.
9. Bring a healthy carbohydrate snack to eat following your test.
10. If you are experiencing a fever or severe cold or flu or are taking antibiotics, please reschedule your fitness assessment.

Informed Consent for Participation in Exercise Testing and Programming

1. Purpose and explanation of procedure:

I hereby consent to voluntarily engage in an acceptable plan of personal fitness. I also give consent to be placed in personal fitness training program activities that are recommended to me for improvement of my general health and well-being. These may include but are not limited to dietary counseling, stress management and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test as well as other fitness tests prior to the start of my personal fitness training program in order to evaluate and assess my present level of fitness. I will be given exact personal instructions regarding the amount and kind of exercise I should do. Professionally trained, college-degreed, nationally credentialed exercise professionals will provide leadership to direct my activities, monitor my performance and evaluate my effort. Depending on my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. I understand I am expected to follow staff instructions with regard to exercise, diet, stress management and other health/fitness-related programs. If I am taking prescribed medications, I have already so informed my exercise professional and will inform my exercise professional of any changes my doctor or I make with regard to the use of them or new medication I may be prescribed in the future. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of my program.

I have been informed that during my participation in the personal fitness training program, I will voluntarily complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort, dizziness, lightheadedness or similar occurrences appear. At any point, I understand that it is my complete right to decrease or stop exercise, and it is my obligation to inform the exercise professionals of the HYFC of my symptoms, should any develop.

I understand that while I exercise, an exercise professional will periodically monitor my performance and perhaps measure my pulse and blood pressure or assess my feelings of effort for the purpose of monitoring my progress. I also understand that the exercise professional may reduce or stop my exercise program when any of these findings indicate that this should be done for my safety and benefit.

I understand that during the performance of my personal fitness training program, physical touching and/or positioning of my body may be necessary to ensure that I am using proper technique and body alignment. I expressly consent to physical contact for these reasons.

2. Risks:

I understand and have been informed that there exists the remote possibility of adverse changes occurring during exercise including, but not limited to: abnormal blood pressure, fainting, dizziness, disorders of heart rhythm; in rare instances heart attack, stroke and even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to injuries to muscles, ligaments, tendons and joints of the body. I have been told every effort will be made to minimize these occurrences by proper staff assessments of my condition before each exercise session, by staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated. I further understand that there are also other unidentified or unknown risks that may be associated with this personal fitness-training program. Despite the fact that complete accounting of all these unidentified and unknown risks has not been provided to me, it is still my desire to participate.

3. Benefits:

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise sessions and personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program's instructions, I will likely improve my exercise capacity and fitness level after a period of time.

4. Confidentiality:

I understand that the Lehigh Valley Health Network (LVHN) Healthy You Fitness Center may collect, use and disclose information about me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used or disclosed to carry out treatment, payment or health care operations.

The LVHN Healthy You Fitness Center will provide me, upon request, with a Notice of Privacy Practices, which more completely describes such uses and disclosures. If I so desire, the LVHN Healthy You Fitness Center will provide this notice prior to my signing this form, in accordance with my right to review its practice before signing consent.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read it. I have been given the opportunity to ask and have answered any questions I may have.

I expressly consent to the rendition of all services and procedures as explained by all program personnel.

PARTICIPANT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (if under 21 years of age) _____

STAFF SIGNATURE _____ DATE _____

Locations

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Healthy You Fitness Center Membership Contract

1. Parties

This Membership Contract (the "Contract") is made this _____ day of _____, 20____ between Lehigh Valley Health Network for its Healthy You Fitness Center ("HYFC"), and _____, as the Member ("Member"). The Member is hereinafter sometimes referred to collectively as "you" or "your."

2. Member Information

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____ CELL PHONE _____

BIRTH DATE _____ E-MAIL ADDRESS _____

EMPLOYER _____ POSITION _____ WORK PHONE _____

IN EMERGENCY, PLEASE CONTACT _____ RELATIONSHIP _____

PHONE _____ ALTERNATE PHONE _____

CHOICE PLUS ID _____ SUBSCRIBER _____

3. Description Of Membership

You have purchased the type of membership indicated below:

Individual Senior (60 and over) Family Other _____

Applications for family memberships will only be accepted for individuals residing at the same address. If a family membership, list names and their birth dates:

4. Membership Terms and Cost

Your membership starts today. The Membership Dues are \$ _____ per month. Except as expressly provided in this Contract or otherwise required by law, the Membership Dues are not refundable. You shall pay the Membership Dues on the first of the month for that month. In the event membership begins on a date different than the first of the month, the initial payment shall be pro-rated to reflect the actual time the membership was in effect. Payment shall be made through direct debit or credit card. In the event you would like to terminate your membership, notice shall be accompanied by an HYFC Membership Account Change Form and return of Member's membership card. If one or more person(s) of a family membership terminates their membership, the remaining member(s) dues will be adjusted to meet the appropriate membership dues.

5. Automatic Payment Plan for Monthly Dues

You hereby authorize HYFC, to undertake the following credit card charges or withdrawals by Electronic Funds Transfer (EFT) for the payment of Monthly Dues:

CHARGE CREDIT CARD: MasterCard Visa Discover American Express

NAME ON CARD _____ ACCOUNT NO. _____

EXP. DATE _____ CV CODE _____ SIGNATURE _____

OR

WITHDRAW FROM BANK ACCOUNT: CHECKING SAVINGS BANK NAME _____

ACCOUNT NO. _____ ROUTING NO. _____

SIGNATURE _____

6. Additional Terms and Conditions

You have agreed to be bound by the additional Terms and Conditions set forth as follows below.

a. Membership - In order to obtain and maintain membership, member must complete the participant screening form, and if necessary obtain medical clearance from his/her treating physician by completing and submitting HYFC's medical clearance form prior to commencement of membership.

Memberships at HYFC are open to individuals who have attained the age of eighteen (18) years or fourteen (14) years of age with parental permission. Sales of memberships are subject to their availability. HYFC will issue a membership card to all members which must be presented before entering the HYFC. Membership cards are not transferable. You will be in default on this Contract if you do not follow any of the provisions of this Contract, including without limitation the Rules and Regulations of HYFC. If you are in default, HYFC may, at its option, terminate your membership privileges.

b. Membership Fees - The Membership Fee of HYFC consists of Monthly Membership Dues. HYFC may, from time to time, in its sole discretion increase or otherwise amend the Monthly Membership Dues or other fees it imposes upon members and guests by giving thirty (30) days prior written notice of the change. The posting of the amendments in HYFC facilities will constitute written notice for this purpose. Amendments shall become effective on the date specified on the notice.

c. Management - The classification of members, the amount of Membership Fees payable by the members of each class, the suspension and expulsion of members, the use of facilities and equipment, programs, hours, guest policies and all other matters affecting or relating to the members or membership or the facilities of HYFC shall be directed by and subject to the sole discretion of HYFC. HYFC reserves the right to close or relocate HYFC, to repair, alter, modify, discontinue or remove any facilities, equipment or programs of HYFC, or to change the times when such facilities, equipment or programs are available for use; and, except as expressly provided herein, you will not be entitled to a refund, deduction from any portion of the Membership Fee.

d. Nondiscrimination - It shall be the policy of HYFC to accept applications for membership from any individual, couple or family without regard to race, sexual orientation, creed, color, age, religion, disability, ancestry, gender, sex or national origin or other characteristics protected by applicable law.

e. Termination - HYFC reserves the right at any time to terminate immediately the membership of any member for failure to comply with this Contract, the Rules and Regulations adopted by HYFC, or conduct which is detrimental to HYFC, or to the health and safety of the staff or other members or guests. Terminated members will be required to immediately return their membership cards to HYFC. The terminated member will remain liable for all Membership Fees and other costs, fees, or charges incurred prior to receipt of the membership card by HYFC. In the event HYFC does not open for business or closes, this Contract will be terminated.

Members may cancel for any reason by providing 30 day written notice via registered or certified mail, return receipt requested, or completing a "Membership Account Change Form" in person at the Member Service Desk. Members may terminate the Agreement if HYFC closes for more than thirty (30) days and fails to provide a comparable facility within ten (10) miles of the location of HYFC. Upon receipt of notice of cancellation, HYFC shall refund all fees paid in excess of the time HYFC was open. If Member dies or becomes permanently disabled, upon receipt of termination notice, HYFC shall refund all fees paid in excess of the time Member became permanently disabled.

f. Holding a Membership - Maintaining a Membership without Paying Full Monthly Dues - Members may request that their membership be placed on hold according to the following restrictions:

1. Requests to hold a Membership must be in writing, sent to the Member Service Coordinator.
2. Requests for holding a membership may be honored for medical reasons, temporary relocation, and extenuating circumstances and are subject to approval by the Director of Corporate and Community Fitness.
3. Membership must be put on hold for a minimum of one (1) month and must not exceed six (6) months.
4. If one person on a family membership freezes the membership, the remaining member(s) pays the regular membership dues.

g. Extension of Membership Term - If a substantial portion of HYFC's facilities are unavailable due to an event such as a fire, strike, flood, loss of lease or the like, the member shall be entitled to either extend the contract period equal to that during which the Center is closed or to receive a prorated refund of the amount paid.

h. Assignment: Transfer - You may not transfer your HYFC membership. If you attempt to transfer your membership in violation of this paragraph, such attempted transfer shall be null and void. You may not loan your membership card to anyone.

i. Rules and Regulations - You shall comply with any and all Rules and Regulations of HYFC. The rules contained herein are not inclusive. Amendments to HYFC's Terms and Conditions, and Rules and Regulations, may be made from time to time as necessary. On all questions regarding the interpretation of HYFC's Terms and Conditions or Rules and Regulations, the decision of HYFC will be final.

j. Guests - All guests must be accompanied by a member and such member will be responsible for their guests. Each guest must (a) pay a guest fee; (b) be over fourteen (14) years of age; and (c) sign a Waiver and Release of liability furnished by HYFC. Member may not bring the same guest to HYFC more than one (1) time in a six (6) month period.

k. No Interest - Membership does not confer any interest in the property of HYFC or any right to participate in the management of HYFC.

l. Default - If procedures for enforcement of any provisions hereof are instituted, Member agrees to pay all costs incurred for such enforcement, including, but not limited to, reasonable attorneys' fees if HYFC is prevailing party.

m. Governing Law - This Contract is governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania and, without regard to choice of law principles to the extent preempted, by the laws of the United States.

n. Entire Agreement - You understand that this Contract, and the documents referred herein, constitute the entire agreement pertaining to membership and supersede any other promises, representations or understandings of any kind, whether written or oral, made with respect to the subject matter hereof. This Contract may be modified only by a signed writing, signed by both parties to this Contract.

o. Severability - Whenever possible, each provision of this Contract shall be interpreted in such manner as to be effective and valid under applicable law. If there is any provision of this Contract or the application thereof to any party or circumstance, which shall be prohibited by, or invalid under applicable law, such provision shall be ineffective to the minimal extent of such prohibition or invalidity without invalidating the remainder of such provision or the remaining provisions of this Contract, or the application of such provisions to other parties or circumstances

7. Right to Cancellation

You may cancel this contract at any time before midnight of the third business day after receiving a copy of a fully signed contract. If you choose to cancel this contract, you must either: send a signed and dated written notice of cancellation by registered or certified mail, return receipt requested; or personally deliver a signed and dated written notice of cancellation to the HYFC. If you cancel this contract within the three-day period, you are entitled to a full refund of your money. If the third business day falls on a Sunday or holiday, notice is timely given if it is mailed or delivered as specified in this notice on the next business day. Refunds must be made within 30 days of receipt of the cancellation notice to the health club. "Business day" means any calendar day on which patrons may inspect and use the health club's facilities and services during a period of at least eight hours, except holidays and Sundays.

8. Waiver and Release

Member fully comprehends and assumes all risks involved in his/her use of the physical fitness equipment in the HYFC. Member acknowledges that he/she has been advised to consult his/her physician prior to use of the physical fitness equipment to ensure that member is physically able to engage in strenuous physical activity.

Member assumes any risks normally associated with the use of HYFC or its facilities and the participation in activities or programs conducted at HYFC. This representation and warranty is made by the member with the knowledge that HYFC is relying upon it in connection with the sale of the membership. HYFC reserves the right to exclude a member from participation in any activity if HYFC believes that such member's participation in such activity could result in a direct threat to the health and safety of the member, other members, guests, or the staff of HYFC.

Member warrants and represents that he/she has no disability, impairment or ailment that will prevent him/her from engaging in any active or passive exercise or activity that will be detrimental to his/her health, safety or physical condition if he/she does participate in such

exercise or activity at HYFC. Member acknowledges that HYFC is relying on the representation made by member in the general fitness contract in order to provide membership privileges.

Being fully cognizant, and assuming all risks involved in the physical conditioning program offered by fitness center, member does hereby remise, release, quitclaim and forever discharge LVHN, its parent or affiliates, together with all their officers, directors, its employees or agents, administrators, successors and assigns (hereafter referred to as "the releases") of and from any and all manner of actions, suits, debts, accounts, damages, judgments, executions, claims or demands whatsoever in law or equity, or otherwise, which against the releases, member's heirs, executors, or administrators hereafter can, shall or may have, for, upon or by reason of any injury that member may sustain or incur while using the facilities of the HYFC, or while engaging in physical conditioning exercises. In consideration of being accepted as a member of HYFC, member does hereby assume all risks of his/her involvement and covenants and agrees not to bring legal action for damages should member sustain any injury.

MEMBER

_____ PRINT NAME	DATE _____
_____ SIGNATURE	_____ PARENT/GUARDIAN SIGNATURE (IF UNDER 18 YEARS OF AGE)

IF A FAMILY MEMBERSHIP IS BEING PURCHASED:

SPOUSE

_____ PRINT NAME	DATE _____
_____ SIGNATURE	

DEPENDANTS

_____ PRINT NAME	DATE _____
_____ SIGNATURE	_____ PRINT NAME
	_____ SIGNATURE

LEHIGH VALLEY HEALTH NETWORK approved by

_____ NAME	DATE _____
_____ TITLE	_____ SIGNATURE

Culture of Wellness Reimbursement Policy Acknowledgement Fitness Center Membership

MEMBER NAME _____

CHOICE PLUS MEMBER ID _____

CHOICE PLUS ENROLLEE (if not the member) _____

Standards for Culture of Wellness Reimbursement for Healthy You Fitness Center (HYFC) Membership:

- Members will be entitled to Choice Plus Culture of Wellness reimbursement only for those months in which a minimum of 8 fitness center visits is documented.
- Each member is responsible for checking him/ herself in at the beginning of each visit to the center via the Member Service Desk. No member may check in for another member and only visits documented in the HYFC membership application will be honored.
- Each visit must include a minimum of a ½ hour duration of structured exercise. The Healthy You Fitness Center is unable to count visits that do not meet these guidelines.
- Any concerns related to HYFC membership or Culture of Wellness reimbursement may be addressed to the member services staff of the HYFC or Spectrum Administrators, Inc.
- Choice Plus members are reminded that at LVHN all interactions begin with PRIDE.

I have reviewed and acknowledge the guidelines for Culture of Wellness fitness center reimbursement as stated above.

MEMBER SIGNATURE _____ DATE _____

STAFF SIGNATURE _____ DATE _____