7150 Halcyon Park Drive, Montgomery, AL 36117 | 334.440.3330

MEMBERSHIP APPLICATION AND PAYMENT AGREEMENT

Date of Application: _____ Referral Source:_____ Membership Type: _____

Enrollment Fee: $_____ Pro-Rated Amount: $_____ Total: $_____

Member Information

Name: _____ DOB: _____

Mailing Address: _____

Street

_____

City State Zip

Main Phone: _____ Cell_____ Text Permission: Yes / No

Email Address: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: _____

Employer: _____

Payment Agreement

This Agreement by and between Jackson Wellness Center and Member for the purchase of a Jackson Wellness Center membership shall be effective the **1st** of _____ (month) and will automatically renew on a month-to-month basis the 1st day of each month. Member agrees to pay the monthly draft of $_____.

Cancellation of Membership shall be effective thirty (30) days after receipt by Jackson Wellness Center of written notice.

Member Signature: _____ *Date:* _____

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MEDICAL DISCLOSURE FORM

Member Name: _____ Date: _____

Sex: □ Male □ Female DOB: _____ Age: _____ Smoker: □ Yes □ No

If yes, how long? _____

Any known medical conditions you have concerns about?

_____

Physician: _____ Phone: _____

Medical Emergency Contact: _____ Phone: _____

Please check if you have or have had any of the following conditions or symptoms:

_____ Heart Attack

_____ Heart Valve Disease

_____ Heart Surgery

_____ Heart Failure

_____ Pacemaker/Implantable cardiac defibrillator, or rhythm disturbance

_____ Heart Transplantation

_____ Congenital Heart Disease

_____ Cardiac Catheterization

_____ Coronary Angioplasty (PTCA)

_____ You experience chest discomfort with exertion.

_____ You experience unreasonable breathlessness.

_____ You experience dizziness, fainting, or blackouts.

_____ You are a woman older than 55 years.

_____ You are pregnant.

_____ You have had surgery in the last 12 months.

_____ You are a man older than 45 years.

_____ You have a bone or joint problem that could be aggravated by exercise.

_____ You are diabetic. If yes, how is it controlled? _____

_____ You have high blood pressure. If yes, are you on medication? _____

_____ You are taking any medications or drugs. If yes, please list:

_____

_____

_____ You are allergic to any medications. If yes, please list: _____

This form is intended for information purposes only. It in no way represents acceptability to participate in any exercise activity. A consultation with your physician should be completed before starting any exercise program.

Member Signature: _____ Date: _____