SOUTH CENTRAL WELLNESS CENTER

SOUTH CENTRAL SPORTS PERFORMANCE+

SC Wellness Center and/or SC Sports Performance+ Membership Agreement

This certifies that _____ is a member of SC Wellness Center and/or SC Sports Performance+, and is entitled to all rights and privileges of membership. These rights and privileges are granted so long as monthly payments of $_____ are made when due. A total of $____ is to be paid, which includes a one-time joining fee and first month's dues. All members are subject to the policies and procedures of SC Wellness Center and/or SC Sports Performance+. Any member failing to obey these policies and procedures is subject to having membership privileges revoked at the discretion of management without reimbursement of any fees. _____ (initial)

Membership dues are processed on the 10th of the month. All cancellations or holds must be done before the 10th of the month, or the member will be responsible for dues that month. Membership cancellation may be submitted at any time. Members will be responsible for dues until written notification of cancellation is received in the business office. Payment of membership dues may not be interrupted for any reason, including non-usage, other than an official medical leave of absence. _____ (initial)

A medical leave of absence will require: written notification to the business office prior to leave, account must be current and paid in full, management approval must be granted, and physician consent in order to return to exercise. _____ (initial)

We have a hold policy stating that you may put your membership on hold for up to 3 months without payment if written notification is documented. After 3 months' time, it is the member's responsibility to inform personnel to take it off hold or keep it on hold for another 3 months. Failure to notify personnel will result in termination of membership. _____ (initial)

SC Wellness Center and/or SC Sports Performance+ shall, from time to time, determine the amount and dues which shall be payable by the member. All policies and procedures may be repealed, revised, or supplemented at any time at the sole discretion of the management. Reasonable advance notice will be given to the membership of any such change or discontinuance. _____ (initial)

Date: _____ Name: _____

Membership #: _____ SCRMC Representative: _____

I/WE HAVE RECEIVED, READ, AND UNDERSTAND THE ABOVE INFORMATION REGUARDING MY WELLNESS CENTER MEMBERSHIP.

DATE: _____ MEMBER SIGNATURE: _____

GUARDIAN: _____
(If Under 18)

PARTICIPANT RELEASE AND AGREEMENT FOR EXERCISE PROGRAM, SPORTS PERFORMANCE FITNESS TRAINING, AND/OR HIGH INTENSITY INTERVAL TRAINING

I, _____, wish to participate in an exercise program, Sports Performance Fitness Training, and/or High Intensity Interval Training program offered by the Wellness Center of South Central Regional Medical Center. I understand that the results of any program cannot be guaranteed, and my progress depends on my effort and cooperation in and outside of the sessions. I understand that there are inherent risks in participating in a program of exercise, whether of a conservative or strenuous nature. I further understand that the appropriate method of determining my physical capability to participate in a program is a personal medical evaluation by a physician of my choice prior to commencement of my participation in one of these programs. I understand and agree that South Central Regional Medical Center has not assumed the responsibility for a physical evaluation of my capability prior to the commencement of my participation in a program at the Wellness Center. I understand that I am expected to follow staff instructions with regard to exercise and rules of the Wellness Center. If I am taking prescribed medications, I have already so informed Wellness Center staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these medications. To the best of my knowledge, I am in good health and well able to participate in any or all of the programs.

I understand that there exists the remote possibility, during exercise, of adverse changes including abnormal blood pressure, fainting, disorders, or heart rhythm, and very rare instances of heart attack. I understand that there is risk of injury or heart attack (in rare instances) as a result of my exercise, but knowing those risks, it is my desire to participate as herein indicated. If, during my exercise at the Wellness Center, I have any symptoms of fatigue, nausea, shortness of breath, chest discomfort, lightheadedness, dizziness, or experience any discomfort, I understand it is my right to refuse such participation in a program at any time, and it is my responsibility to inform the staff of these symptoms. I agree to comply with the terms and conditions of my program.

I agree that South Central Regional Medical Center shall not be liable or responsible for any injuries or illnesses of mine resulting from participation in a program, and I expressly discharge, covenant not to sue, hold harmless, and indemnify South Central Medical Center, its trustees, owners, officers, employees, agents and/or assigns, from any and all claims, actions, judgments, and the like which I or my heirs, executors, administrators, or assigns may have or claim to have as a result of any illness or injury or any other damage which may occur in connection with my participation in a program by South Central Regional Medical Center, my presence on South Central Regional Medical Center's property, or any medical assistance I receive as a result of participating in a program or being present on the property. This Release shall be binding upon my heirs, executors, administrators, and assigns. I further agree to the use of any information derived from my program for research and statistical purposes as long as it does not identify my person or provide facts that could lead to my identification. Any other information obtained will be used only by the program staff in the course of prescribing exercise for me and evaluating my fitness in a program.

I understand that, for participation in the Sports Performance Fitness Training, my rate may be based on a session of a specific amount of time, and that should I arrive late, there is no guarantee I will receive the full session with my trainer. I understand that South Central Regional Medical Center Sports Performance Trainers operate on a scheduled appointment basis and thus require that I provide twenty-four (24) hours advance notice when canceling an appointment. Should I cancel a session with less than twenty-four (24) hours prior notice, I understand that I will be charged in full for that session. No charge will be levied should I cancel with more than twenty-four (24) hours advance notice given, but I understand the importance of rescheduling to insure consistency and fitness progress.

I have read and understood this Release and Agreement, and I fully understand all of its terms. I have been given an opportunity to ask any questions, and each of my questions has been answered to my satisfaction. This document is signed by me freely and voluntarily with full knowledge of its significance.

_____	_____	_____
WITNESS	PARTICIPANT/MEMBER	DATE

IF PARTICIPANT IS A MINOR: (under 18 years of age)

_____	_____	_____
WITNESS	PARENT OR GUARDIAN	DATE

Membership

All information received on these forms will be confidential. Please fill out the following forms completely and accurately. This information is essential in joining SC Wellness Center and/or SC Sports Performance+.

Name: _____ Membership #: _____

Address: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

Marital Status: Married Single

Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Emergency Contact Name & Phone Number: _____

Personal Physician: _____

List Any Family Members that are Current Members of SC Wellness Center and/or Sports Performance+:

_____

_____

Referred By: _____

Personal Fitness/Health Goals: _____

_____

JOINING AND ASSESSMENT FEES ARE NON-REFUNDABLE

For Office Use Only

Joining Fee: $_____ Corporate: Y N

Assessment Fee: $_____

Monthly Dues: $_____ Corporation: _____

Total: $_____

HEALTH QUESTIONNAIRE

Name:_____

Age:_____ Date of Birth:_____/_____/_____

Please read each question carefully and answer every question honestly.

YES	**NO**	**1. Has a doctor ever said that you have a heart condition?**
YES	**NO**	**2. Do you feel pain in your chest at rest, during your daily activities, or when you do physical activity?**
YES	**NO**	**3. Do you lose balance because of dizziness or have you lost consciousness in the past 12 months?**
YES	**NO**	**4. Do you have diabetes?**
YES	**NO**	5. Do you have high blood pressure or a heart condition for which a physician is currently prescribing a medication?
YES	**NO**	**5a. Is your high blood pressure well controlled?**
YES	**NO**	**6. Have you had surgery within the last six (6) months?**
YES	**NO**	7. Do you have an injury or orthopedic condition (such as back, hip, or knee problem) that may worsen due to a change in your physical activity?
YES	**NO**	8. Are you 69 years of age and not used to being active?

- IF YOU ANSWERED **YES** TO QUESTIONS 1 – 4 OR 6, OR IF YOU ANSWERED **NO** TO QUESTION 5A, YOU WILL BE REQUIRED TO PRESENT A PHYSICIAN'S AUTHORIZATION TO PARTICIPATE IN EXERCISE AT SC WELLNESS CENTER AND/OR SC SPORTS PERFORMACE+ PRIOR TO ANY PARTICIPATION.
- If you answered YES to any of the above questions, consult your doctor before becoming physically active. Inform your doctor of these responses and advise him/her how you plan to exercise.
- If you honestly answered NO to all questions, you can likely increase your level of physical activity gradually.
- If your health changes such that you could then answer YES to any of the above questions, seek guidance from a physician.

Print Name:_____

Signature:_____ Date:_____/_____/_____

Signature of Parent:_____ Date:_____/_____/_____

(If Under 18 Years of Age)

Health History

Please check any of the following conditions you now have or have experienced in the past. Check all that apply.

- ☐ Male 45 years of age or older
- ☐ Female 55 years of age or older
- ☐ Heart attack, coronary bypass, cardiac surgery, stroke
- ☐ Abnormal resting or stress EKG
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Chest pain at rest or exertion
- ☐ Currently pregnant – If so, how many months? _____
- ☐ Orthopedic problems – If so, explain: _____
- ☐ Elevated cholesterol
- ☐ Seizures
- ☐ Pulmonary/Lung disease/Asthma
- ☐ Dizziness
- ☐ Bronchitis
- ☐ Gave birth in the last 6 months
- ☐ Recent illness, hospitalizations, or surgical procedures – If so, explain: _____
- ☐ Uneven, irregular, or skipped heart beats
- ☐ Abnormal blood lipids
- ☐ Family history of cardiovascular disease (prior to age 50)
- ☐ Depression
- ☐ Fatigue or lack of energy
- ☐ Migraines or recurring headache
- ☐ Anemia
- ☐ Hernia
- ☐ Phlebitis Emboli
- ☐ Rheumatic fever
- ☐ Shortness of breath at rest or with exertion
- ☐ Arthritis
- ☐ Emotional disorders
- ☐ Drug Allergies
- ☐ Smoking – If so, how many packs daily? _____
- ☐ Alcohol – If so, how many drinks a week? _____
- ☐ Cramping
- ☐ Other: _____

COVENANT NOT TO SUE AND AGREEMENT PERTAINING TO SWIMMING POOL USAGE AT SC WELLNESS CENTER

I, _____, covenantor, for myself and for my heirs, legal representatives, and assigns, in consideration of being allowed pool privileges and the usage of the swimming pool within the Wellness Center of South Central Regional Medical Center in Laurel, Mississippi, do hereby covenant with South Central Regional Medical Center, its agents, employees, trustees, and representatives (covenantees) to never institute and suit, claim, demand, or cause of action at law or in equity against South Central Regional Medical Center, its agents, employees, trustees, and representatives by reason of any claim that I now have or may hereafter acquire arising out of the usage of the swimming pool and the wet areas immediately adjacent thereto in the Wellness Center of South Central Regional Medical Center in Laurel, Mississippi.

The covenantor understands and has been advised of the policy of South Central Regional Medical Center that no person may enter the pool or swim alone and that swimming is at the own risk of each person utilizing the swimming pool within the Wellness Center. The undersigned covenantor understands that children under the age of fourteen (14) are not allowed in the swimming pool. Covenantor, likewise covenants that he/she will never, as guardian or next friend of a minor, institute any such action at law or in equity against South Central Regional Medical Center, its agents, employees, trustees, and representatives on account of any injury, or loss of damage sustained or that might be sustained in the future by a minor child of the covenantor as a consequence of the usage of the swimming pool.

The covenantor understands that the Wellness Center provides no lifeguard. Pool privileges are at the member's own risk. Covenantor agrees to use the pool only when another person is present in the area and agrees not to enter or remain in the pool when no other individual is in the pool area. The covenantor recognizes the inherent risk in usage of the swimming pool and the wet areas immediately adjacent thereto and the even greater risk of utilizing the swimming pool when alone.

The covenantor expressly agrees that this instrument may be pleaded as a defense to any action of proceeding that may be brought, instituted or taken by the covenantor or by others on behalf of the covenantor, and shall forever be a complete bar to commencement of an action or proceeding against the covenantees on account of any injuries or damages sustained by the covenantor, and shall forever be a complete bar to commencement of an action or proceeding against the covenantees on account of any injuries or damages sustained by the covenantor as herein mentioned.

Covenantor expressly agrees to indemnify South Central Regional Medical center, its agents, employees, trustees, and representatives against any loss from any and all claims, demands, actions or complaints of any kind that may hereafter be brought against the covenantees by or behalf of the covenantor for the purpose of pursuing a claim for damages sustained as a result of usage of the swimming pool and the wet areas immediately adjacent thereto.

Covenantor has read this covenant and agreement and understands all of its terms. This instrument is executed voluntarily and with full knowledge of its significance.

_____

Covenantor

I witness whereof, the covenantor and the covenantees have executed this Covenant and Agreement on _____.

_____

Witness

Policy and Procedure Agreement

SC Wellness Center and/or SC Sports Performance+ Admission:

- All members must present scan card to receptionist at the front desk upon each visit to SC Wellness Center and/or SC Sports Performance+.
- If you forget your scan card, the receptionist will have to enter your visit manually and verify your active status.
- If you lose your scan card, stop by the front desk and purchase a new scan card ($5.00)

Guests:

Guest Fee: $10.00 per Visit (SC Wellness Center Only)
All guests must fill out a guest consent form.
Guests under the age of 18 must have Legal Guardian's signature before using facility. Guest must be 14 years or older.

Locker Rentals and Personal Items:

SC Wellness Center and/or SC Sports Performance+ will provide lockers on a daily basis.
Members are responsible for all personal items, including padlock, to secure items in day use lockers.
All items are removed from the locker rooms on a nightly basis.
Any items not claimed after one week will be donated to charity.
Rental lockers are available for $5 per month (SC Wellness Center Only).
Monthly fees not paid by the 25th will result in removal of items from locker.
SCRMC will not be held liable for lost, damaged, or stolen articles of clothing or other personal property of members or guests.

I, _____, hereby understand the terms and conditions stated above and consent to any revisions or amendments to these policies and procedures by SC Wellness Center and/or SC Sports Performance+. All amendments will be posted within SC Wellness Center and/or SC Sports Performance+ for member viewing. Should revisions or amendments affect individuals or group activities/classes, members will be given a reasonable notice in advance.

_____ _____

Member Signature Staff Signature

SOUTH CENTRAL
REGIONAL MEDICAL CENTER

Photo and Promotional Release Consent Form

I hereby consent to be photographed, videotaped, or filmed by representatives of South Central Regional Medical Center, its subsidiaries and affiliates for purposes of publication, display, or broadcast (print, web, digital display, and all other forms of media).

I agree that such photographs, films, or video and/or any reproductions of same in any form, are the property of South Central Regional Medical Center, its subsidiaries and affiliates, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness.

I hereby release South Central Regional Medical Center, its subsidiaries, affiliates, employees, representatives, and agents from any and all claims, demands, costs, and liability that may arise from the use of these recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being recorded, photographed, videotaped, or filmed.

I understand that I may revoke this authorization at any time by providing written notification to South Central Regional Medical Center, 1220 Jefferson Street, Laurel, MS 39440, Attn: Marketing Department. However, the revocation will not be valid if South Central Regional Medical Center, its subsidiaries, and/or affiliates have taken action in reliance on this authorization. This authorization expires only upon written notice from the undersigned individual.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Name (print): _____

Signature: _____

Date: _____

*Parent or Legal Guardian name (print): _____

*Parent or Legal Guardian signature: _____

**Parent or Legal Guardian name and signature required for individuals under 18 years of age.*

DO NOT WRITE BELOW THIS LINE

SOUTH CENTRAL REGIONAL MEDICAL CENTER
1220 Jefferson Street, Laurel, MS 39440
601-426-4000 scrmc.com

PRCONSENT

SOUTH CENTRAL WELLNESS CENTER

SOUTH CENTRAL SPORTS PERFORMANCE+

AUTHORIZATION FOR DIRECT PAYMENT VIA ACH (ACH DEBITS)

Direct payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment. I authorize South Central Regional Medical Center ("COMPANY") to electronically debit my account (and, if necessary, electronically credit my account to correct erroneous debits) as follows:

Checking Account / Savings Account (select one) at the depository financial institution named below ("DEPOSITORY"). I agree that ACH transactions I authorize comply with all applicable law.

Depository Name _____

Routing Number _____ Account Number _____

Amount of debit(s) _____

Or specific range of amount or debit(s) _____ (The method used to determine the amount) _____

Dates(s) and/or frequency of debit(s): _____
(daily/monthly/quarterly/annually)

I understand that this authorization will remain in full force and effect until I notify South Central Regional Medical Center in writing, by phone or in person that I wish to revoke this authorization. I (we) understand that COMPANY requires to be notified by the 10th of the month in order to cancel this authorization.

Name(s) _____

Signature(s) _____

Date _____