ELEMENTS
WELLNESS CENTER
COMMUNITY FIRST SOLUTIONS

HEALTHWAYS SilverSneakers FITNESS

SILVERSNEAKERS® MEMBER AGREEMENT

___ Mr. ___ Miss ___ Ms. ___ Mrs. Date: _____

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____

State _____ Zip _____ Phone Number _____

Email Address _____

Male _____ Female _____ Age _____ Birth Date _____ /_____ /_____

How did you hear about Elements?

_____

_____

Insurance Company Name: _____

Insurance Member ID: _____

_____

Office Use Only:

Healthways ID: _____ - _____ - _____ - _____ Shape.Net ID: _____

_____

Please check if you have any of the below conditions:

___ Chest pains while at rest and/or during exertion ___ Previous heart attack
___ High blood pressure ___ Diabetes
___ Frequent, fast, irregular heartbeats or very slow heartbeats
___ Previous hip or spinal fracture (as an adult)
___ Shortness of breath after mild exertion, at rest, or in bed
___ Open cuts on your feet that don't seem to heal
___ An unexplained weight loss of ten (10) pounds or more in the past six (6) months
___ An heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure,
poor circulation to the legs, valvular heart disease, or blood clots
___ More than two (2) falls in the past year (no matter what reason)
___ More than one year since you have engaged in regular physical activity

Is your physician UNAWARE of any of these conditions? ___ Yes ___ No

Has your physician recommended any limitations to your physical activity? ___ Yes ___ No

Please sign that you understand the above questions and have completed this assessment.

Name (please print): _____

Signature: _____Date: _____

Waiver and Assumption of Risk

Please consult with your physician before beginning any exercise program.

I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the "Programs"). I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue any class instructor, any Healthways participating location, any sponsoring organization, Healthways, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read and understand this waiver and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location or individual.

I hereby grant Community First Solutions permission to take photographs and/or videos of myself and use reproductions of said photographs for the purpose of promoting the organization through advertising, marketing, or public relations.

In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs.

- Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Diabetes
- Previous hip or spinal fracture (as an adult)
- Lung disease or shortness of breath after mild exertion, at rest, or in bed
- Open cuts on my feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- More than two falls in the past year (no matter what the reason)
- More than one year since I have engaged in regular physical activity

_____	_____	_____
Print Member's Name	Member's Signature	Date
_____	_____	
Emergency Contact Name	Contact Phone Number	

Please email completed form to acrossley@community-first.org or bring to your first Elements visit.