HEALTHWAYS

Healthways Sneakers Fitness Program

Activity Readiness Assessment

Please read and consider the following list of conditions. To protect your privacy, please DO NOT WRITE anything next to them:

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 do not seem to heal
An unexplained weight loss of ten (10) pounds or more in the past six (6) months
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
Lung disease
More than two falls in the past year (no matter what the reason)
More than one year since you have engaged in regular physical activity

1. Is your physician unaware of any of the above conditions?

Check One ☐ Yes ☐ No

2. Has your physician recommended any limitations to your physical activity?

Check One ☐ Yes ☐ No

Please sign that you understand the above questions and have completed this assessment. Ask your Program Advisor if you have any questions or concerns.

Name (Please print): ______________________________

Signature: ______________________ Today's date: ______________

Note:
You may be asked to obtain a signed Release for Activity or a note from your health care provider allowing you to participate before starting the program. If you are not asked to obtain a release, you are cleared to begin a gradual program of regular exercise.

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HEALTHWAYS

Physical Activity Waiver

I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise. I acknowledge that the strenuous nature of the program and the risks associated with my participation in the program have been explained to me, including, but not limited to, risks of physical injury, abnormal blood pressure, heart attack and death; and risks associated with the negligence of a Healthways participating location and any other organization participating or involved in providing or promoting any classes, functions, programs, testing, or other activities that I participate in at a Healthways location (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 program, including, but not limited to, the negligence of a Healthways participating location and any other organization participating or involved in providing or promoting any classes, functions, programs, testing, or other activities that I participate in at a participating location (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue a class instructor, a Healthways participating location, any sponsoring organization, Healthways, Inc., or any of its subsidiaries or any other organization providing or promoting classes, functions, programs, testing, or other activities that I participated in at a Healthways location (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 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, understand, had explained to me, and had the opportunity to ask questions concerning this waiver, release, 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.

____
Print Member's Name

______________________________ ______________________________
Member's Signature Date

______________________________ ______________________________
Emergency Contact Name Contact Phone Number

______________________________ ______________________________
Participating Location Name and Staff Signature Date

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DiSepio Institute for Rural Health and Wellness
Fitness Center
Community Membership Application

Date:_________
New: _______
Renewal _____
Membersip ID_____

MEMBER INFORMATION

First name: ____________________ Last name: ____________________

Address: ____

City: ____________________ State: ______ Zip: __________

Home Phone: __(___)______________ Work Phone: __(___)__________

Email: ____

Gender: (Circle One): Male Female Date of Birth (mm/dd/yy): __________

EMERGENCY CONTACT

Name: ______________________________

Relationship: ______________________________

Phone: __(___)______________________________

MEDICAL HISTORY

Heart Trouble	Yes	No	High Blood Pressure	Yes	No
Palpitations	Yes	No	High Cholesterol	Yes	No
Lung Disease	Yes	No	Asthma	Yes	No
Chest Pain w/Exercise	Yes	No	Chest Pain at Rest	Yes	No
Heart Murmur	Yes	No	Abnormal EKG	Yes	No
Claudication	Yes	No	Dizzy Spells	Yes	No
Shortness of Breath	Yes	No	Lung Disease	Yes	No
Diabetes	Yes	No	Smoker	Yes	No
Joint Pain	Yes	No	Fainting	Yes	No
Swelling of ankles	Yes	No	Cancer	Yes	No
Seizures	Yes	No	Stroke	Yes	No

I realize that my answers to the above and following questions will be considered by the DiSepio Fitness Center in determining whether I shall be permitted to participate in certain programs offered by the Center and accordingly I certify that such answers are true and correct and in the event that any such answers should prove to be untrue, I release the DiSepio Fitness Center and Saint Francis University from any and all liability, costs, damage, and expenses resulting from its reliance thereof.

Member Signature: ______________________________ Date__________

Image and Likeness Permission:

I further consent to the use of the DiSepio Fitness Center Member or Participant's name, image, and likeness depicting his/her participation in the event (in any literary, audio, visual, photographic, film, video, or other form) by the DiSepio Institute and Saint Francis University for archival and promotional material only.

Signature: ______________________________ Date: __________

The DiSepio Institute For Rural Health and Wellness
at Saint Francis University
Release and Waiver of Liability Form

HEALTH STATEMENT: In requesting permission to access or use the equipment at the DiSepio Institute for Rural Health and Wellness at Saint Francis University, I affirm that my general health is good and that I am not adversely affected by the exercise that I will undertake. If I am not I am not currently under the care of a physician , I understand that it is my responsibility (and not the responsibility of the Fitness Center) to consult a physician and express to them my desire to participate in a an exercise program. If I am under the care of a physician, I affirm that I have received his/her permission to participate in physical activity at the DiSepio Institute.

AGREEMENT TO FOLLOW RULES AND POLICIES: I understand that the DiSepio Institute for Rural Health and Wellness at Saint Francis University provides both directed and self-directed programs. I understand that I may be provided a general overview of the equipment. Fitness instruction is available, upon request, by trained staff members. I agree to follow all rules and policies of the DiSepio Institute. I agree to abide by any reasonable requests concerning use of the facility as directed to me by the staff of the DiSepio Institute. I agree to operate and use the equipment only in the manner in which it was intended and designed to use, therefore following all written and verbal instructions provided by the staff at the DiSepio Institute. I understand that if I fail to abide by and follow instructions or requests by the staff, this may result in the termination of my privileges at the facility. I further understand that the staff at the DiSepio Institute has the right to terminate or alter my privileges at the facility at their discretion. Membership fees would not be refunded to individuals that have had their privileges terminated at the facility.

RELEASE AND WAIVER: I hereby accept all risks, known and unknown, to my health that are associated with my access to the DiSepio Institute for Rural Health and Wellness. I accept all risks to my health, risk of injury, or even death that may result from my participation in activities and exercise sessions at the facility. I release the facility for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result or occur during my use of the facilities, whether caused by negligence of the DiSepio Institute, the University, its governing board, officers, employees, or representatives or otherwise. I agree to release and hold harmless the DiSepio Institute for Rural Health and Wellness at Saint Francis University and its employees from any and all liability whatsoever which may result from my use of the facility or the equipment. This statement shall serve as a release and hold harmless the DiSepio Institute for Rural Health and Wellness and its employees by my heirs, executors, administrators, if any and me.

I have carefully read this agreement and understand it to be a release and waiver of all claims and causes of action for my injury or death or damage to my property that occurs while using the DiSepio Institute for Rural Health and Wellness and it obligates me to indemnify the parties named for any liability for injury or death of any person and damage to property caused by my negligent or intentional act or omission.

Signature:________________________________ Date:____________

Name (please print): ____

REQUIRED PARENT/GUARDIAN SIGNATURE FOR MINOR PARTICIPANTS

I am the parent or legal guardian of ____________________ and am registering ____________________ to participate in a program or activity offered by the DiSepio Fitness Center. I have read and reviewed this Agreement, and am voluntarily signing it on behalf of my child/ward ____________________ in my capacity as parent and legal guardian. By signing below, I am agreeing on behalf of my child/ward to be bound along with my child/ward by all terms and conditions of this Agreement as set forth above, including but expressly not limited to those terms and conditions pertaining to taking of photographs of program and activity participants, the use and publication of such photographs and the release of all claims associated therewith.

Signature:____________________________________

STAFF USE ONLY

Cleared to exercise________ Not cleared to exercise_______

Reason____

Staff signature________________________ Date__________

DISEPIO INSTITUTE FOR RURAL HEALTH AND WELLNESS
108 FRANCISCAN WAY
LORETTO, PA 15940

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the DiSepio Institute to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by DiSepio Institute for Rural Health and Wellness (the "DiSepio Institute") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the DiSepio Institute maintains a Privacy Notice which sets forth the types of uses and disclosures that the DiSepio Institute is permitted to make under the Privacy Regulations and sets forth in detail the way in which the DiSepio Institute will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the DiSepio Institute has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the DiSepio Institute at the following address:
   108 FRANCISCAN WAY, LORETTO, PA 15940, Attention: Heather Meck, Saint Francis University/DiSepio Institute Compliance Officer.

4. I understand and acknowledge that I have the right to request that the DiSepio Institute restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the DiSepio Institute is not required to agree to restrictions requested by me, but if the DiSepio Institute agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the DiSepio Institute's use and/or disclosure of my health information (leave blank if no restrictions):

   ____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE DISEPIO INSTITUTE'S POLICY NOTICE AND AGREE TO THE DISEPIO INSTITUTE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________ ______________
Signature of Client or Representative Date

____
Client's Name

____
Date of Birth

____
Social Security Number

______________________________ ______________
Name of Personal Representative (if applicable) Relationship to Client

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<u>*To Be Completed by the DiSepio Institute*</u>

The requested restrictions on the use and/or disclosure of the client's health information set forth above are:

_________ Accepted _________ Denied _________ Not Applicable

_________ Other (explain) ______________________________

______________________________ ______________
Signature of Authorized DiSepio Institute Representative Date