

990 Ribaut Road
Beaufort, SC 29902



Phone: 843-522-5635
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We are excited about your interest in the LifeFit Wellness Center!
Here is what you need for your first appointment to start you on your way to a healthier lifestyle.

- Please bring this **completed** packet to your first appointment.
- You must have your **membership payment and billing information** (a check or credit card is needed to be set up with automatic monthly deductions) to your first appointment.*
 - ***If you do not bring your payment/billing information with you to your first appointment, then your appointment will have to be rescheduled.**
- Additional services may be scheduled upon request:
 - **Basal Metabolic Rate Assessment - \$50**
 - **Body Fat Assessment (Skinfold measurements) & girth - \$30**
 - **Dietician consultation (30 min) - \$30**
 - **Hb A1C - \$20**
 - **Cholesterol Screening/Lipid Panel- \$20**
 - **Functional Movement Screen Package-\$100**

BUSINESS HOURS

Monday - Thursday: 5:00am - 8:00pm

Friday: 5:00am - 7:00pm

Saturday: 8:00am - noon



Name Prefix/Title: Mr. Mrs. Miss Ms. Dr.

First Name: _____

Last Name: _____

Name you wish to be called: _____

Date of Birth: (mm/dd/yyyy): ____/____/____ Gender: Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Race: African American Asian Caucasian Native American Other

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Current Marital Status: Single Married Divorced Widowed

Emergency Contact Person: _____ Phone: _____

Emergency Contact's Address: _____

City: _____ State: _____ Zip: _____

Relationship to you: _____

How did you hear about us? _____

Please list all the medications that you take below.

Please include prescription and over-the-counter medications, including vitamins.

Medication	Dosage	Frequency Times per day	Reason

Physician Information

Please list your primary physician and any other specialty physicians you see.

Physician	Specialty

- Do you have Health Insurance, Medicaid or Medicare? YES NO

Allergies

Please list any known allergies you have.

Are you a smoker? YES NO If yes, how many packs a day? _____

Goals:

Please check all that apply

- Aerobic Fitness
- Gain Muscle Mass
- Gain Strength
- Improve Muscle Tone
- Increase Endurance
- Lose Inches
- Lose Weight
- Reduce Body Fat

Past Medical History

Please check all that apply and indicate the date of diagnosis/surgery:

- Hypertension _____
- High Cholesterol _____
- Diabetes _____
- Cancer _____
- Stroke _____
- Heart Attack _____
- Cardiac Surgery _____
- Orthopedic sugery/repair _____
- Neuropathy _____
- Other _____

Fall Risk:

Please check all that apply:

- Have fallen in the last 6 months
- Have diagnosed neuropathy in feet
- Use an assisted device to walk (cane, walker, wheelchair, etc.)



LifeFit Wellness Center Rules for Participation

1. Check in with your ID card at the front desk (no need to check out).
2. Proper Attire:
 - a. Comfortable workout clothes
 - b. Shirt is required at all times
 - c. Closed toed shoes (no sandals, boots, cleats)
3. Clinical programs have priority on equipment in their space during specific posted times (see staff for details)
4. No food or drink in the facility
 - a. Water is allowed in a sealed container.
5. Locker Room Rules:
 - a. We are not responsible for lost or stolen items – locks may not always be available, so please bring your own to ensure no lost or stolen items.
 - b. Towels
 - i. Hand towels are provided (see staff).
 - ii. Shower towels are not provided, so please bring your own.
6. Equipment Rules
 - a. Please wipe down perspiration from all equipment with a spray bottle and towel.
 - b. Please limit time on cardiovascular equipment to 30 minutes.
 - i. If no one is waiting, there is no time limit.
 - c. Abuse of any equipment is grounds for termination of membership.
 - d. You are ultimately responsible for any wrongful use of equipment.
 - e. Report any problems with any piece of equipment to the staff immediately.
 - f. Please be respectful with personal headphones. If someone complains we will ask that you turn your headset down.
 - g. Do not rest on equipment between sets. Please allow others to work in.
7. Cell Phone Use
 - a. We ask that you do not use your cell phone while in the LifeFit Wellness Center.
 - b. Please discontinue use of equipment while on the cell phone.
 - c. If you must accept a call, please be courteous to others and step in the lobby or outside the building.
8. General Rules
 - a. If you have questions or concerns, please notify one of the LifeFit Staff Members.
 - b. Any time during exercise you are not feeling well, please let a member of the staff know immediately.
 - c. Notify staff of any medical/medication changes after your initial evaluation.

Signature: _____ Date: _____



MEMBERSHIP AGREEMENT

Membership:

1. Memberships are open-ended with no contract requirements and no cancellation fees.
2. Membership dues are billed on the first of each month.
3. Monthly membership fees may be paid by any of the following: EFT/ACH, credit card or payroll deduction.
 - a. A \$5 surcharge will be applied for the use of credit or debit cards for auto-billing
4. Members that are not able to participate or object to the above method may take advantage of the following:
 - a. Payment by check, credit card, or cash for a minimum of 3 months in advance.
 - b. NSF fee of \$30 is added to any payments returned.
5. Family Memberships are available to immediate family members at the same primary address.
6. Membership includes the following:
 - a. An initial evaluation including measurements, cholesterol screening and body composition
 - b. Develop and review goals along with an exercise prescription
 - c. Follow-ups that are a mandatory part of membership every 6 or 12 months depending on your initial evaluation.
 - d. Access to Heart Rate monitors and locks for the lockers in exchange for keys or other personal belonging during the workout.
 - e. Discounted Massage Therapy and Personal Training rates
 - f. Unlimited use of the facility during normal business hours
 - g. Unlimited Group Fitness classes

Freeze Policy:

1. Members have the ability to freeze their accounts one month at a time but not exceeding 12 months.
2. For all non-medical freezes, there will be a monthly fee of \$5 per account.
 - a. A \$5 surcharge will be applied for the use of credit or debit cards for auto-billing
3. Medical freezes can be on hold for up to 12 months with no charge.
4. All freeze requests must be put in writing by the 15th of the month prior freezing.
5. All non-medical freezes will be terminated after 12 months.

Cancellation Policy:

1. LifeFit members may cancel without penalty with a notice in writing.
2. All cancellations must be put in writing by the 15th of the month prior cancellation.

Paid in Full Policy:

1. With Paid in Full memberships, you are not able to freeze your account.
2. There will be no refunds to terminating your membership prior to the expiration date.

Signature: _____ Date: _____



I, _____, intend to participate in some or all of the activities, facilities, programs, and services offered by LifeFit Wellness Center and I understand that each person has a different capacity for participating in such activities, facilities, programs, and services. I assume full responsibility during and after my participation, for my choices to use any of the equipment and services available to me, at my own risk. I also assume full responsibility for my choice to use or apply, at my own risk, any portion of the information or instruction that I may receive.

I understand that part of the risk involved in undertaking any fitness or health activity or program is relative to my own state of fitness and health (physical, mental, and/or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, service, or program of LifeFit, even if my participation is suggested or encouraged by LifeFit, brings with it my assumption of those risks or results stemming from this choice and the fitness, health, awareness, care and skill that I have and use.

I recognize that by participating in the activities, facilities, program, and services offered by LifeFit, I may experience potential health risks such as, but not limited to, transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps and nausea, and in rare cases heart attack, stroke, or death. I willfully and knowingly assume those risks. I acknowledge and understand that I have an obligation to immediately inform the nearest LifeFit employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand and am aware that fitness and health exercise and activities, including the use of equipment, are potentially hazardous activities and involve a risk of injury. I understand that I may stop or delay my participation in any activity or procedure if I desire and that I may also be requested to stop activities by a LifeFit employee who observes any symptoms of distress or abnormal response.

I authorize the LifeFit Wellness Center staff to perform the necessary ongoing tests and evaluations to assess my progress toward goals set forth during the initial evaluation. The results of any evaluation and/or tests will be provided directly to me. I understand that it is my responsibility, and not the responsibility of LifeFit Wellness to have the results of the evaluations and/or other tests reviewed by my physician or other healthcare provider to determine the meaning of the test results and to determine what further healthcare services I may need as a result of the evaluations and/or tests.

I hereby release and forever discharge LifeFit, BMH, its agents, employees, officers, directors, affiliates, successors and assigns from any and all claims, demands, causes of action, rights of action, suits, liabilities, expenses and damages of every kind, nature and description.

I acknowledge that I am not receiving treatment of any kind, nature or description, and that there is no hospital-patient or doctor-patient relationship between LifeFit and/or BMH and me as a result of these services. I further acknowledge that this Informed Consent, Medical Authorization and Release of Liability apply to any services that are provided to me at anytime by the LifeFit Program. I further acknowledge and declare that I have read, understood and agree to the contents of this Informed Consent, Medical Authorization and Release of Liability Agreement in its entirety.

Signature: _____ Date: _____

Witness: _____ Date: _____