Fit 2 Function

HEALTH HISTORY and SERVICE AGREEMENT

Name _____ DOB_____ Age_____ □ Male □ Female

Address: _____ City/State: _____ Zip:_____

Phone: _____ Accept texts: Y/N Email address:_____

Emergency Contact _____ Phone _____

Physician's Name_____ Physician's Phone _____

Do you now have, or have you had in the past:	**Yes**	**No**
1. History of heart problems, chest pain, or stroke	□	□
2. Blood pressure issues (high or low)	□	□
3. Any chronic illness or condition	□	□
4. Advice from physician not to exercise	□	□
5. Recent surgery (last 12 months)	□	□
6. History of breathing or lung problems	□	□
7. Diabetes or metabolic syndrome	□	□
8. Joint conditions/surgeries	□	□

Explanation of conditions

_____

_____

List of Medications that may impact your ability to exercise

Type of Medication	**For what condition**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
□ Check with nursing (if reside in assisted living)	□ Check with nursing (if reside in assisted living)

Would you be interested in being added to our email list for future correspondence from Goodcare AtHome Rehab?

□Yes □No Email address: _____

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Fee for Fit 2 Function Sessions

☐ Option A: Initial consultation (45 minutes) is $75.00. Sessions are $15.00/15 minute increments.
This is the option most clients choose. Your Fit 2 Function coach is certified as a personal trainer or exercise specialist. Your coach will develop a program specific to your fitness goals.

☐ Option B: $25.00/15 minutes for a licensed therapist OR $20.00/15 minutes for licensed therapist assistant.
This option is for those who have just been discharged from therapy services, but desire to continue working with one of our licensed therapists/assistants on your fitness goals. An ABN form, stating you are aware the services are no longer billable to insurance, is required.

Any equipment your coach recommends and is desired by you, is your responsibility to purchase

Service Agreement and Waiver and Release of Liability

I, the undersigned, agree and understand that:

a) The exercises or activities I am participating in are not skilled therapy. I am not under the direct care of licensed therapist (Option A) or a under therapy plan of treatment (Option A and B).
b) The exercises or activities are wellness in nature and not billable to my insurance plan.
c) There may be others participating in wellness exercises in the same location, at the same time.
d) I am advised to consult with my physician before beginning or changing my exercise regimen, and that it is my responsibility to do so. Any direction from my physician should be communicated to my Fit2Function coach prior to my next session.
e) Weight training, aerobic exercise, and other exercises or activities may result in injury to myself and others.
f) I assume all risks of injury incurred or suffered while working with Goodcare AtHome Rehab and, if applicable, on the premises of their partner facilities. I hereby waive, release, and discharge any and all claims for damages for personal injury, death, or property damage which I have, or which may hereafter accrue to me (its officers, officials, employees, and agents) from any and all liability arising out of or connected in any way with my participation in said activities, even though that liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above. It is further agreed that this waiver, release and assumption of risk is to be binding on my heirs and assigns. I agree to indemnify and to hold the above persons or entities free and harmless from any loss, liability, damage, cost, or expense, which may incur as a result of my death or injury or property damage that I may sustain while participating in said activities.

I, the undersigned, acknowledge that I have carefully read, fully understand and agree to the above statements.

I also agree to the fee for services I selected above and will remit payment within 15 days of receipt of billing statement. If payment is not received within 30 days, a 1.5% late fee will be assessed each month the payment is overdue. I will notify the company if the billing address is different than address provided in this agreement.

_____ _____
Client Name (Printed) **Date**

_____ _____
Client signature (or POA signature) **Relationship if POA**