

Burke Rehabilitation Hospital - Fitness Center
785 Mamaroneck Ave. White Plains NY 10605 P: 914.597.2805 F: 914.597.2809
NEP Tuesdays and Thursdays 4:30-6:30p NEP Mondays and Wednesdays 4:30-6:30p

The Burke Neurological Exercise Program - NEP

10/29/2024

BURKE
REHABILITATION

Fitness
Center

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785 Mamaroneck Ave. White Plains NY 10605 P:914.597.2805 F:914.597.2809
NEP Session I: Mondays & Wednesdays 4:30-6:30p
NEP Session II: Tuesdays & Thursdays 4:30-6:30p

Burke Neurological Exercise Program - NEP

Welcome to the Burke Neurological Exercise Program
and thank you for considering Burke in making fitness a part of your life!

Burke Neurological Exercise Program provides a supervised group exercise program on equipment appropriate for individuals with neurologic impairments and wheelchair users, who want to maintain or improve their cardiovascular and muscular stamina. Members are guided through a structured warmup, cardiovascular and weight training circuit and cool down. Our trainers are specialists who have earned degrees in exercise science and/or are certified by nationally recognized and accredited agencies including, but not limited to, the American College of Sports Medicine and the National Academy of Sports Medicine.

Burke Neurological Exercise Program is not physical therapy, and medical insurance does not cover membership charges. The Burke Neurological Exercise Program is a self-pay program.

All prospective members will be screened to determine if a caregiver is required during the exercise session to assist the participant with their exercise program. Physician approval is required by all participants.



Enrollment Process:

STEP 1 Complete pages 2-8.

Physician Approval (last page):

You complete the top of the page and your doctor signs as indicated on the form.
Your doctor's office can FAX your physician approval form to 914 597-2809.

STEP 2 Return all forms to the Burke Adult Fitness Center.

We will call you when all forms have been received.

If you have any questions please call, 914-597-2805. We look forward to meeting you!

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SCREENING

Name: _____

How did you hear about us? _____

Address: _____ City/State/Zip: _____

DOB: ___/___/___ Gender: _____ Primary Phone: _____

Email: _____

What is your diagnosis? _____

In the case of an emergency, please notify: _____

Home: _____ Cell: _____

Do you have a caregiver or home health aide who will attend the program with you? Yes No

Have you ever participated in an exercise program? Yes No If so when? _____

What do you hope to gain by joining the Neurological Exercise Program? _____

Are you a wheelchair user? Yes No

Are you able to bear weight through your legs? Yes No Date last stood? _____

Do you have a home health attendant? Yes No

Please list any medications and dietary supplements you are taking

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Have there ever been any complications or limitations from any of the aforementioned conditions or events which may be aggravated by exercise? If yes, please explain briefly:

Do you have a joint replacement? Yes No Date: _____ If yes, which joint has been replaced?

Have you been restricted from any activity or use of this joint? _____

Do you have a pacemaker or any implanted device? Yes No

Recent Bone Density Scan: _____ Past Surgical history: _____

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RISK REVIEW

Name: _____ Phone: _____ Date: _____

| Risk Factor | ACSM RISK FACTOR DEFINING CRITERIA | YES | NO | NOT SURE |
|--|---|------------|-----------|-----------------|
| Age | Are you a male over the age of 55 or a female over the age of 65? | | | |
| Family History | Has there been a heart attack, coronary bypass, or sudden death before age 55 in father or male first-degree relative (i.e. brother or son) or in mother before age 65 or other female first degree relative (i.e. sister or daughter)? | | | |
| Cigarette Smoking | Are you a current cigarette smoker or have you quit within the previous 6 months? | | | |
| High Cholesterol (Dyslipidemia) | Has your doctor prescribed medication to lower your cholesterol? | | | |
| Fasting Glucose | Have there been any abnormal fasting glucose measurements on at least 2 separate occasions? | | | |
| Obesity | Is your waistline over 40 inches if you are male or 35 inches if you are female? | | | |
| High Blood Pressure | Has your doctor prescribed medication to control your blood pressure, or, have you had a blood pressure measurement over 140/90 on at least 2 separate occasions? | | | |
| Sedentary Lifestyle | Are you participating in a regular exercise program or do you participate in 30 minutes of aerobic activity most days of the week? | | | |
| Table 2- Have you had any of the following symptoms recently? | | YES | NO | NOT SURE |
| Pain, discomfort in the chest, neck, jaw, arms or other areas during exertion? | | | | |
| Shortness of breath during rest or mild exertion? | | | | |
| Dizziness? | | | | |
| Rapid extra heart beats you can feel? | | | | |
| Significant pain in the lower legs at rest or mild activity (pain level makes you stop)? | | | | |
| Ankle Swelling? | | | | |
| Do you have a known heart murmur? | | | | |
| Unusual fatigue or shortness of breath with usual activities? | | | | |

The Burke Neurological Exercise Program - NEP

PERSONAL HEALTH HISTORY

Name: _____ Date: _____

Please Select All Known Health Conditions That May Apply

Cardiovascular

Date

| | |
|------------------------------------|--|
| Chest Discomfort | |
| Current Heart Murmur | |
| Extra, Skipped or Rapid Heart beat | |
| Heart Attack | |
| High Blood Pressure | |
| High Cholesterol | |
| Low Blood Pressure | |
| Peripheral Vascular Disease | |
| Phlebitis or Emboli | |
| Coronary Artery Bypass Surgery | |
| Stroke | |
| Pacemaker or Defibrillator | |
| Cardiovascular Surgery | |
| Congenital Heart Disease | |
| Atrial Fibrillation | |
| Aneurysm | |
| Heart Transplant | |
| Heart Valve Disease | |
| Coronary Angioplasty/Stents | |
| Aortic Stenosis | |
| Congestive Heart Failure | |

Pulmonary

| | |
|----------------------------------|--|
| Allergies | |
| Asthma | |
| Emphysema | |
| Bronchitis or Chronic Bronchitis | |
| Pulmonary Embolism | |
| Cystic Fibrosis | |
| Pneumonia | |
| Pulmonary Edema | |
| Pulmonary Hypertension | |
| Oxygen Therapy (_____ L/min.) | |

Musculoskeletal

Date

| | |
|--------------------------------|--|
| Ankle Swelling | |
| Back Issues | |
| Broken Bones (Recent ≤ 1 year) | |
| Fibromyalgia | |
| Foot Issues | |
| Limited Motion in Joints | |
| Lupus | |
| Neck Issues | |
| Osteoarthritis | |
| Osteoporosis | |
| Rheumatoid Arthritis | |
| Shoulder Issues | |
| Knee Issues | |
| Swollen, Sore, Painful Joints | |
| Amputation | |

Neurological

| | |
|--------------------------------|--|
| Multiple Sclerosis | |
| Peripheral Neuropathy | |
| Parkinson's Disease | |
| Cerebral Palsy | |
| Traumatic Brain Injury | |
| Dementia/Alzheimer's | |
| Spinal Cord Injury | |
| Cerebrovascular Accident (CVA) | |
| Other: | |

Other

| | |
|---------------------------------|--|
| Diabetes | |
| Mental Health Issue | |
| Meniere's/Vestibular/Vertigo | |
| Epilepsy or Seizures | |
| Hearing or Vision Impairment | |
| Voice/Speech Impairment | |
| Chronic Liver or Kidney Disease | |
| Cancer historic | |
| Cancer current | |
| Pregnant/Post-Natal | |

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MEMBERSHIP POLICIES

| | |
|---|--|
| MEMBERSHIP | Members will enroll in Electronic Funds Transfer (EFT) at time of enrollment. An enrollment fee is required for all new members and memberships that have been expired for one year or more. All memberships are charged automatically monthly until a cancellation is received. Cancellation: Members may cancel, for any reason, with a 14-day written notice. |
| MEMBERSHIP DUES | Dues will be collected at the beginning of each month, for the prior month. Burke Fitness Center must be notified of ANY credit card changes immediately (i.e. new credit card, new account number, new expiration date, etc.) New memberships: The enrollment fee and first month's membership fee will be charged to the member's credit card in the month following the in-person Initial Personal Training. Dues for the first month of the membership will be prorated |
| HOURS OF OPERATION | The Burke Rehabilitation Hospital reserves the right to change its fitness center hours of operation for any reason, such as changes in member usage, maintenance repairs, community service activities, holidays or government guidance. |
| RATE CHANGE | Monthly rates and all policies of the Burke Fitness Center are subject to change unless protected for set periods of time indicated within this agreement. A minimum 30-day notice in writing to all members will precede any change. Where automatic charges have been authorized, we will assume any rate changes are accepted by the member unless notified in writing. |
| CHANGES IN MEDICAL STATUS | We require that our members inform NEP of any changes in medical status that may impact participation in exercise. Members are required to stay home if they are experiencing any symptoms related to any illness, including COVID-19. |
| MEMBERSHIP SUSPENSION OR TERMINATION BY THE BURKE FITNESS CENTER | We reserve the right to suspend or terminate your membership, or any member on your membership, at any time for a failure to comply with these or any of our other rules, regulations, procedures or policies (which may be amended as necessary), or for conduct we determine to be improper or contrary to our best interests. You may not be entitled to refund of dues paid. |
| DEFAULT AND LATE PAYMENT | Should you default on any payment obligation as called for in this agreement, the entire remaining balance shall be deemed due and payable upon demand, and you agree to pay allowable interest, and all cost of collection, including, but not limited to, collection agency fees, court costs and attorneys' fees. Should any monthly payment become more than 10 days past due, you will be charged a late fee to cover additional administrative expenses and other expenses related to obtaining your payment. A fee will be charged for all returned payments. |
| PAYMENT SUSPENSION | Due to the popularity of NEP, memberships may not be put on freeze for any reason. If the NEP member is not able to attend their sessions for more than four consecutive weeks, due to a medical or non-medical issue, the NEP membership will be forfeited. The member may re-apply for membership when they return. |
| ENTIRE AGREEMENT | This agreement constitutes the entire and exclusive agreement between parties. Any promise, representation, understanding and/or agreement pertaining directly or indirectly to the agreement may be modified only by an instrument in writing. Employees are not authorized to make any independent agreements, which are not the center's policy, with any member. |
| NEP PHYSICAL TRANSFERS | Members who can't perform all exercises independently are required to have a caregiver for support. Members who need assistance transferring from wheelchair to equipment and out of equipment back to the wheelchair, are required to have a caregiver for support. Caregivers must be capable of assisting safely. Burke reserves the right to determine if transfers are safe. |

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MEMBERSHIP POLICIES continued

MEMBERS AGREE TO ACT IN ACCORDANCE WITH THE POLICIES OF THE BURKE NEUROLOGICAL EXERCISE PROGRAM AS PROMULGATED FROM TIME TO TIME. Violation of these rules may be the cause for suspension or cancellation of membership without refund. They include:

- Athletic attire and shoes in good condition should be worn at all times during exercise sessions.
- No open toe or open back shoes.
- Proper hydration is essential before, during, and after exercise.
- Cool water is available at two water stations or from the vending machine.
- Stop exercise immediately if you feel discomfort or pain. Make staff aware.
Members are responsible for informing the staff of their past and present health information that may have an effect on their exercise program.
- Do not use any piece of equipment without prior instruction from staff.
- Do not use any piece of equipment if it appears damaged or broken. Please report any broken equipment to a staff member.
- Observe a 20-minute time limit on any piece of equipment when there is another member waiting.
- Members are responsible for keeping their appointment times and when they are unable to do so for any reason, notifying the Neurological Exercise Program as soon as possible.
- Please turn your phone off or on vibrate while exercising and take phone calls in the lobby.
- Participants are expected to be courteous of each other and staff.
- Courteous behavior includes, but is not limited to appropriate language and gestures.
- Members must strictly follow workout protocol set forth by the Fitness Center Staff.

RULES OF CONDUCT:

Use all safety precautions.

Use a spotter during exercising when necessary.

Put all equipment in proper place when finished.

Observe a 20-minute limit on any piece of equipment if there are members waiting.

Only members and caretakers are allowed in the gym area during gym hours.

No children allowed in the workout area.

No food or gum chewing allowed in the workout area.

Please use trash receptacles for all waste.

Member's Signature

Date

The Burke Neurological Exercise Program - NEP

WAIVER

I, _____ wish to enroll in the Neurological Exercise Program at The Burke Rehabilitation Hospital. I understand that exercising in this program may involve a variety of physical activities including, but not limited to stretching; strengthening with weight training machines and devices; exercising on motorized and non-motorized exercise machines; use of various aerobic conditioning machinery. I understand that participation in this program is voluntary and not medically prescribed therapy. I hereby affirm that I do not now suffer, nor have I ever suffered, from any medical condition, impairment or disability that would prevent or limit in any way my participation in this program.

I fully understand and assume risk that I may suffer injury as a result of my participation in the Neurological Exercise Program. These risks include, but are not limited to, changes in blood pressure or heart rate, dizziness, muscle strain or pulls, soreness and in rare cases serious illness such as heart attack. There is some risk of injury to bones, joints, and/or muscles. I am willing to assume such risk. My physician approves of my participation in this program.

In consideration of my participation in The Burke Rehabilitation Hospital Neurological Exercise Program, I for myself, my heirs, executors, administrators, representatives and assigns hereby discharge The Burke Rehabilitation Hospital, its employees, subsidiaries, affiliates, offices, directors, agents, successors, assigns, and/or representatives, from any and all claims, demands, causes of action, suits, charges, liabilities, and expenses (including attorney's fees) of any nature whatsoever, now or in the future, arising from my participation in the Neurological Exercise Program including but not limited to liability related to the injuries listed above, however caused, whether they occur during or after my participation in these programs.

I hereby affirm that I have read and fully understand the above, and that my signing of this waiver is knowing and voluntary.

SIGNATURE _____

DATE _____

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AGREEMENT

INDIVIDUAL MEMBERSHIP: MONTHLY PAYMENT

\$80 PER MONTH
\$55 ENROLLMENT
PLUS \$100 ORIENTATION FEE FOR COMMUNITY MEMBERS

Credit Card # _____ CVV _____ Exp _____

Name as it appears on the credit card _____

X _____
Member Signature

Date

Print Name

Staff Use Only: Enrollment Date ___/___/___

The Burke Neurological Exercise Program - NEP

Patient's Name: _____ Phone: _____

Physician Approval and Recommendations for Exercise

To be completed by your physician

Your Patient _____ (Name of Participant) would like to participate in an exercise program at the Burke Neurological Exercise Program, a non-clinical fitness facility that provides a variety of cardiovascular, strength, flexibility and balance activities. **This is not physical therapy. This is a Fitness Instructor guided exercise session.**

Vital signs: HR _____ BP _____ RR _____ SpO2 _____

Please check one of the following:

_____ **YES**, my patient is eligible to participate in an exercise program. My patient has no current unstable medical problems that are a contraindication to participating in an exercise program.

_____ **NO**, my patient is not eligible to participate in an exercise program due to his or her current medical status.

My patient's diagnosis (if applicable):

My patient should observe the following restrictions and/or recommendations:

Exercise Heart Rate Restrictions (Optional)

Please restrict my patient from vigorous exercise.

Exercise heart rate range: _____ - _____ BPM; and/or not to exceed: _____ BPM

=====

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

PLEASE FAX COMPLETED FORM TO 914-597-2809