Fitness Center
Burke Rehabilitation Hospital l Adult Fitness Center
P: 914.597.2805 F: 914.597.2809
785 Mamaroneck Ave. White Plains NY 10605

Burke Adult Fitness Center

Welcome to the Burke Adult Fitness Center
Thank you for considering Burke in making fitness a part of your life!

The Burke Adult Fitness Center provides an individualized experience for members ages 40 and over who want to improve and maintain overall health and wellness. Physician approval is required to join. Our fitness instructors have qualifications ranging from master's degrees in exercise physiology to certifications by nationally recognized and accredited agencies, including but not limited to the American College of Sports Medicine, National Strength and Conditioning Association, and National Academy of Sports Medicine.

Physical therapy is not offered at the Burke Adult Fitness Center. However, Burke does provide outpatient physical therapy at many neighboring off site facilities. Medical insurance does not cover charges for use of exercise centers; we recommend calling your insurance provider to see if they offer any reimbursement for membership dues. If you are joining the Burke Adult Fitness Center after finishing physical therapy, you should have your therapist complete a referral form that shows the therapist's exercise recommendations and precautions for post rehabilitation exercise.

Prospective members who have balance or cognitive limitations are welcome but may need assistance throughout the exercise session. In this case he/she may have to have a caregiver present to assist in getting on and off the exercise equipment. The Burke Adult Fitness Center reserves the right to determine whether a prospective member must have a caregiver present.

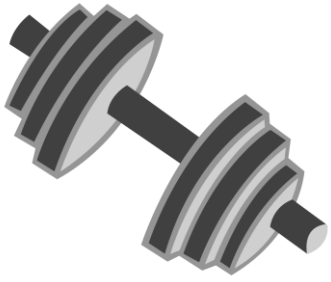
ENROLLMENT PROCESS

Complete all forms

Physician Approval: The member answers the questions on the Risk Review and Physician Approval Form and the member's doctor must complete Physician Approval and Recommendations. Your doctor's office can FAX your physician approval form to 914-597-2809 (they must fax both sides).

Return all forms to the Burke Adult Fitness Center

We will call you to schedule an orientation *only* when all forms have been received.



We encourage you to visit the center and have all concerns addressed.
If you have any questions please call 914-597-2805. We look forward to meeting you!

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Name:_____ Nickname: _____
Address: _____ City/State/Zip: _____
DOB: ___/____/_____ Gender: _____ Primary Phone: _____
Email: _____ FitLinxx ID:_____(filled in by trainer)

Exercise Readiness Questionnaire	Yes	No
Are you over the age of 65 and not accustomed to vigorous exercise?		
Do you have frequent pains in your heart and chest?		
Do you often feel faint or have spells of severe dizziness?		
Has your doctor ever told you your blood pressure was too high?		
Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise?		
Is there a good physical reason why you should not exercise even if you wanted to?		

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	
	Rheumatic Fever	
	Stroke	
	Pacemaker or Defibrillator	
	Cardiovascular Surgery	
	Cardiac Arrhythmia	
	Aortic Stenosis	
	Congestive Heart Failure	
	Pulmonary	
	Allergies	
	Asthma	
	Asthma (Exercise Induced)	
	Bronchitis or Chronic Bronchitis/Emphysema	
	Chronic Recurring Cough	
	Emphysema	
	Pneumonia	
	Pulmonary Edema	
	Pulmonary Hypertension	

	Musculoskeletal	Date
	Ankle Swelling	
	Back Problems	
	Broken Bones (Recent ≤ 1 yr)	
	Fibromyalgia	
	Foot Problems	
	Limited Motion in Joints	
	Lupus	
	Neck Problems	
	Osteoarthritis	
	Osteoporosis	
	Rheumatoid Arthritis	
	Shoulder Problems	
	Recent Surgery	
	Swollen, Sore, Painful Joints	
	Other	
	Anemia	
	Depression	
	Diabetes	
	Epilepsy or Seizures	
	Hearing Impairment	
	Parkinson's	
	Post-Natal	
	Pregnant	
	Cancer	
	Positive TB Test?	
	Oxygen Therapy (___L/min)?	

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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/use of this joint?

_____.

The following paperwork must be completed prior to orientation

	Member Health History, medications, injuries, conditions etc.
	Risk Review and Physician Approval
	Liability Waiver and Facility Rules
	Billing Information

Exercise/Wellness History

Tell us about your history with exercise, physical activity and overall wellness. Why are you interested in a wellness program like Burke Adult Fitness?

What would describe your commitment to your health at this time? (Circle One)

1	I am 100% not committed to my health at this time; I do not practice any healthy lifestyle habits.
2	I am thinking about making a better commitment to my health by incorporating healthy lifestyle habits such as regular exercise and a healthier diet.
3	I currently practice some healthy lifestyle habits but I am hoping to make a stronger commitment to my health.
4	I am mainly committed to my health and I mostly practice healthy lifestyle habits.
5	I am 100% committed to my health and I always practice healthy lifestyle habits.

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MEMBERSHIP POLICIES

MEMBERSHIP DUES	Will be collected at the beginning of each month for the prior month. The Burke Fitness Center must be notified of ANY credit card changes immediately (i.e. new card, new account number, new expiration date, etc.)
MEMBERSHIP TYPES	• An enrollment fee is required for all new members and memberships that have been expired for one year or more. • Members will enroll for an initial contract period of six to twelve months of membership. At the time of enrollment, members may elect to have the 6-month or 12-month membership automatically convert to a month-to-month membership. **Month-to-month membership provides the convenience of cancellation, for any reason, with a 30-day written notice.** Month-to-month memberships are not eligible for any discounts, including 5-year Loyalty Member discounts. The month-to-month Individual membership will be $98 / month. • After the expiration of the initial contract period, six or twelve months, if the member did not sign up for a month-to-month membership, the contract will automatically renew and be charged monthly to the account via credit card. **Automatic renewal of the contract offers a 5-year discount after 60 consecutive months of membership.** Members would receive this discount on the 61st month of continuous membership. The discounted Individual 6-mo membership will be $81/month, Individual 12-mo would be $69/month.
CHECK-IN PROCEDURE	Upon entering The Burke Fitness Center, all members are required to check in at the reception desk using their membership key tag. There is a $5 charge for lost key tags. SilverSneakers® Members must swipe in at the front desk prior to attending classes.
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, or holidays.
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.
FREEZE POLICY	Members may freeze their membership for any reason (medical, vacation, etc.). Freezes are taken in one-month increments only: Six-month contracts may be frozen for 1-3 months. 12-month contracts may be frozen for 1-6 months. During this time, if your membership is billed monthly, you will be charged $10 per person for each month your membership remains on freeze. If you paid for your membership in full, please remit a check made out to Burke Rehabilitation Hospital. Following the expiration of your freeze status, you will be billed your regular monthly dues. If you use the freeze status during your commitment period, your membership expiration date will be extended by the length of time that your account was on freeze. **Family Membership Freeze:** Where only 1 member of a 2-member family is freezing, all of the members' expiration dates will be extended by ½ of the freeze. If you freeze your membership for a medical reason, you must supply a medical clearance to return to exercise Freezes will be considered only one month retroactively with a doctor's note.
LOCKERS	Locker room lockers are provided for daily use only. The Burke Fitness Center reserves the right to remove any articles left in lockers and shall not be liable for locker contents. The Burke Fitness Center, its agents or employees shall not be liable for the loss, theft or damage to the personal property of members. Members are urged not to bring valuables onto the premises.

	All locks left overnight will be removed and locker contents will be placed in Lost and Found. There are also a limited number of overnight lockers available for a six month period for a fee. Please inquire at the front desk for more details.
CHANGES IN MEDICAL STATUS	We request that our members inform the Burke Adult Fitness Center of any changes in medical status that may impact participation in exercise.
MEMBERSHIP SUSPENSION OR TERMINATION BY BURKE ADULT FITNESS	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.
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.
PURCHASER'S RIGHT TO CANCEL	If you do not wish to be bound by this agreement you may cancel by mailing a written notice to the Burke Adult Fitness Center by midnight of the third business day after you sign the agreement. The notice must say that you do not wish to be bound by this agreement. The notice must be delivered or sent by certified mail to: The Burke Fitness Center, 785 Mamaroneck Ave., White Plains, NY 10605. After you cancel, The Burke Fitness Center may request the return of all agreements, and other documents of evidence of membership. If you have received any services within this window, you will be responsible for payment for those services (e.g. orientations, training etc.). i. Once bound by this agreement the consumer may cancel membership only if he/she relocates their residence farther than twenty-five miles from the facility or if he/she cannot receive the services as stated in the contract because of significant physical disability for a period in excess of six months, upon doctor's order in writing. A letter must be sent to Burke Adult Fitness, 785 Mamaroneck Ave White Plains NY 10605. Physicians may fax their order for discontinuation of exercise to 914-597-2809. i. Refunds: All refund requests must be submitted in writing within 1 month of cancelation. Refund of dues collected will be considered only for 1. Significant physical disability that inhibits participation in exercise 2. Extended Hospitalization 3. Death Refund of dues collected will be considered only 1 month retroactively from the date of cancelation. Cancelations submitted on or before the 10th of the month will not be responsible for payment of that month. Cancelations received after the 10th of the month will be responsible for that month's dues. If the member becomes deceased, no lien will be attached to your estate and a prorated share of the unused portion of the membership will be refunded to the estate.

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FITLINXX IDENTIFICATION NUMBER The Burke Fitness Center uses an exercise tracking system called Fitlinxx. This system keeps an automatic log of your workouts and helps our instructors guide your personalized exercise program. Each time you use the facility, you will be required to log into Fitlinxx system with a 5-digit identification number. You can select your own 5-digit number. Your Fitlinxx identification number should be one that is easily remembered, such as 5 digits of your birthday.

☐ Please Choose a FitLinxx Identification Number: __ __ __ __ __

☐ Please assign me a FitLinxx Identification Number: __ __ __ __ __

FACILITY RULES

Violation of these rules may be the cause for suspension or cancellation of membership without refund.

-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 drinking fountains or from the vending machine.
-Please warm-up prior to using equipment and cool down afterward.
-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.
-Observe a 30 minute limit on any piece of equipment if there are members waiting
-Only members, caretakers and approved guests are allowed in the gym area during gym hours
-No Children are allowed in the workout area.
-No Food allowed in the workout area
-Please use trash receptacles for all waste and wipes
-Do not use any piece of equipment if it appears damaged or broken.
Please report any broken equipment to a staff member.
-Members are responsible for keeping all appointments (orientations, re-evaluations), and when they are unable to do so for any reason, notifying the fitness center as soon as possible, preferably with 24 hours notice.
-The Fitness Center provides one complimentary exercise towel for each member; towels are to be returned before leaving the facility. Please bring a towel from home if you wish to shower. Please use tissues provided by the facility to blow your nose, towels are meant for the use of absorbing sweat during and after your workout.
-Cell phones are not allowed in the exercise area, phone calls may be taken in the lobby.
Please turn your phone off or on vibrate while exercising.
-Participants are expected to be courteous of each other and staff.
Courteous behavior includes, but is not limited to appropriate language and gestures.

I AGREE TO ACT IN ACCORDANCE WITH ALL OF THE MEMBER POLICIES AND FACILITY RULES OF THE BURKE FITNESS CENTER AS PROMULGATED FROM TIME TO TIME. I hereby affirm that I have read and fully understand the above and attached, my signing of this waiver is knowing and voluntary.

_____ _____
Member's Signature Date

_____
(Please Print Name)

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COMMUNITY WELLNESS EXERCISE PROGRAM LIABILITY WAIVER

I, _____ wish to join a community wellness exercise program at the Burke Adult Fitness Center located in 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; and walking within the Burke Rehabilitation Hospital grounds. I understand that participation in this program is voluntary and not medically prescribed therapy.

I realize that the reaction of one's body to physical activity cannot be predicted with complete accuracy. There can be abnormal physical responses including but not limited to changes in blood pressure or heart rate, dizziness and in rare cases serious illness including heart attack and death. There is some risk of injury to bones, joints, ligaments, muscles and other connective tissues. I am willing to assume such risks. My physician approves of my participation in this program.

In consideration of my participation in the Burke Adult Fitness Center located in the Burke Rehabilitation Hospital, 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 these programs 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.

Date_____ Signature _____

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THE BURKE FITNESS CENTER MEMBERSHIP AGREEMENT
ALL MEMBERS MUST BE AT LEAST 40 YEARS OF AGE OR HAVE A QUALIFYING MEDICAL CONDITION

FITLINXX ID_____ SCAN CODE _____ MBRSHIP TYPE _____ ORIENT DATE _____

Name _____ DATE OF BIRTH ____/____/____TODAY'S DATE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE _____ HOW DID YOU HEAR ABOUT US? _____

EMAIL _____ WOULD YOU LIKE TO RECEIVE EMAILS? ☐ YES ☐ NO

EMERGENCY CONTACT _____ PHONE _____

INDIVIDUAL MEMBERSHIP

6 Months		12 Months	
☐	Charge credit card monthly $92.00 Plus one time enrollment fee $75.00	☐	Charge credit card monthly $80.50 Plus one time enrollment fee $75.00
☐	Pay in full (includes 5% savings) $524.40 Plus one time enrollment fee $75.00	☐	Pay in full (includes 10% savings) $869.40 Plus one time enrollment fee $75.00

Additional discounts may apply

FAMILY MEMBERSHIP

6 Months		12 Months	
☐	Charge credit card monthly $143.75 Plus one time enrollment fee $100.00	☐	Charge credit card monthly $132.25 Plus one time enrollment fee $100.00
☐	Pay in full (includes 5% savings) $819.38 Plus one time enrollment fee $100.00	☐	Pay in full (includes 10% savings) $1,428.30 Plus one time enrollment fee $100.00

Additional discounts may apply

Contract to Month-to-Month Roll-Over: Contract to Month to Month Roll Over: At the time of enrollment and renewal, members may elect to have a 6- or 12-month membership that will automatically convert to a month-to-month membership. Month-to-month membership provides the convenience of cancellation, for any reason, with a 30-day written notice. Month-to-month memberships are not eligible for any discounts, including 5-year Loyalty Member discounts. 5 year discount: Members are eligible for the 5 year discount after 60 consecutive months of membership. Members would receive this discount on the 61st month of continuous membership

Please enroll me in month to month roll over upon completion of my contract period listed above.
☐ YES ☐ NO

PURCHASER'S RIGHT TO CANCEL: Please view the attached member policies for more information.

X_____
Member Signature

METHOD OF PAYMENT
☐ CREDIT CARD CARD # _____ EXP DATE _____
☐ CHECK for payment in full, only. Please make check out to: Burke Rehabilitation Hospital

Trans Listing___ Type___ Stat ___ JOIN___ Calen___ Exp ___ User____ Drft ____ CODE____ Repet____ Modify Rep___ Note____Flx_____

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RISK REVIEW AND PHYSICIAN APPROVAL FORM

STEP 1: Answer the following questions Step 2: Have physician sign back

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?			

Thank you for helping us guide and encourage your patient to stay active!

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Patient's Name: _____ Patient's Phone:_____ Date:___/___/____

PHYSICIAN APPROVAL AND RECOMMENDATIONS
▫ To be completed by your physician ▫

Potential Moderate Risk	Potential High Risk
Male over age 45	1 or more symptoms from Table 2
Female over age 55	Known cardiovascular, pulmonary or metabolic disease
2 or more YES answers in Table 1	

Aerobic exercise is prescribed at low to moderate levels.
Please indicate on the form below if you want your patient restricted from VIGOROUS exercise.

Low Intensity ≤ 3 METs Moderate Intensity 3-6 METs High Intensity > 6 METs

Note: Moderate intensity may be considered hard or very hard in some sedentary, older or functionally impaired persons. Exercise programs for these persons are adjusted according to physician guidelines and tolerance.

PHYSICIAN CLEARANCE AND RECOMMENDATIONS

I approve of my patient _____ to participate in the Burke Fitness Center exercise program, with the following guidelines/recommendations:

_____

_____

Physician Name: _____

Physician Signature: _____ Date: _____

Physician Phone Number:_____

Exercise Heart Rate Restrictions (Optional)

☐ Please restrict my patient from vigorous exercise.
Exercise heart rate range: _____ - _____ BPM; and/or not to exceed:_____ BPM

Maximum heart rate from exercise stress test (if applicable) _____

Highest workload achieved on exercise stress test (if available)

Speed _____ % Grade _____ Duration of Test _____

PLEASE FAX COMPLETED FORM TO 914.597.2809

Thank you for helping us guide and encourage your patient to stay active!