BURKE Rehabilitation & Research

Burke Rehabilitation Hospital
P: 914.597.2122 F: 914.597.2763
785 Mamaroneck Ave. White Plains NY 10605

Neurological Exercise Program

BURKE NEUROLOGICAL EXERCISE PROGRAM

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 an individualized exercise program on machines appropriate for individuals with neurologic impairments and who are wheelchair bound, who want to maintain or improve their cardiovascular and muscular stamina. Our staff has qualifications ranging from certifications by nationally recognized fitness agencies to doctorate degrees in physical therapy.

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 pre-screened to determine if a caregiver is required during the exercise session to assist the participant with their exercise program. A physician approval is required by all participants.

Enrollment Process:

STEPS 1 – Complete all forms.

Physician Approval:
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 914 597-2763. (Be sure they fax both sides.)

STEP 2 – Return <u>all</u> forms to the Outpatient Physical Therapy Department.

We will call to schedule an orientation <u>only</u> when all forms have been received.

We encourage you to visit the facility and have all concerns addressed.
If you have any questions please call, 914-597-2122! We look forward to meeting you!

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The Burke Neurological Exercise Program

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?			

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Name: ___________________________________ 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 Neuro Gym exercise program, with the following guidelines/recommendations:

____

____

Physician Name: _________________________________

Physician Signature: ______________________________

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!

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Neurological Exercise Program

NEUROLOGICAL EXERCISE PROGRAM SCREENING FORM

Name:_________________________ Nickname: _________________________
Address: _________________________ City/State/Zip: _________________________
DOB: ___/___/_______ Gender: _________ Primary Phone: _________________________
Email: _________________________
What is your diagnosis? _________________________
In the case of an emergency, please notify: _________________________
Home: _________________________ Alternate: _________________________
Primary Language: _________________________

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

How would you describe your general health? ☐Excellent ☐Good ☐Fair ☐Poor

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? _________________________

____

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 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: _________________________
_________________________.

Vital Signs (therapist to fill out): HR__________ BP________ RR________ SaO2________

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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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MEMBERSHIP POLICIES BURKE NEUROLOGICAL EXERCISE PROGRAM

MEMBERSHIP DUES	**Will be collected at the beginning of each month for the prior month. The Burke Neurological Exercise Program must be notified of ANY credit card changes immediately (i.e. new card, new account number, new expiration date, etc.)**
MEMBERSHIP TYPES	Annual/Semi-Annual: Members may pay in full or enroll in Electronic Funds Transfer (EFT) at time of enrollment or renewal for a six or twelve month membership. The membership will expire on the date of enrollment, six or twelve months after joining or renewing. An enrollment fee is required for all new members and memberships that have been expired for one year or more. 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.
CHECK-IN PROCEDURE	Upon entering the Burke Neurological Exercise Program all members are required to check in at the reception desk by signing in.
HOURS OF OPERATION	The Burke Rehabilitation Hospital reserves the right to change its Neurological Exercise Program 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 Neurological Exercise Program 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. 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	We do not provide lockers at the Burke Neurological Exercise Program. The Burke Neurological Exercise Program, its agents or employees shall not be liable for the loss, theft or damage of the personal property of members. Members are urged not to bring personal valuables on premises.
CHANGES IN MEDICAL STATUS	We request that our members inform the Burke Adult Neurological Exercise Program of any changes in medical status that may impact participation in exercise.

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MEMBERSHIP POLICIES BURKE NEUROLOGICAL EXERCISE PROGRAM

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 Neurological Exercise Program 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 Neurological Exercise Program, 785 Mamaroneck Ave., White Plains, NY 10605. After you cancel, The Burke Neurological Exercise Program 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. ii. 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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11. 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 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.
-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 Neurological Exercise Program as soon as possible.
-The Neurological Exercise Program provides one complimentary exercise towel for each member; towels are to be returned before leaving the facility.
-Cell phones are not allowed in the exercise area, take phone calls 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.

12. RULES OF CONDUCT:

Use all safety precautions.
Use a spotter during exercising when necessary.
Put all equipment in proper place when finished.
Observe a 30 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**

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Neurological Exercise Program Liability Waiver

I,______________________________ wish to enroll in the Neurological Exercise Program 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 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, it's 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.

DATE________________SIGNATURE________________________________

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Neurological Exercise Program

THE BURKE NEUROLOGICAL EXERCISE PROGRAM MEMBERSHIP AGREEMENT

NAME____ DATE OF BIRTH ____/____/_______
ADDRESS ____ PHONE ___________________
CITY ____ STATE _______________ ZIP ________________
EMAIL ____ WOULD YOU LIKE TO RECEIVE EMAILS? ☐ YES ☐ NO
EMERGENCY CONTACT___________________________________ PHONE____________________________

Staff Use Only: Enrollment Date ___/___/___

MEMBERSHIP OPTIONS – CHOOSE ONE

INDIVIDUAL MEMBERSHIP: MONTHLY PAYMENT
☐ 6 MONTHS $80.00 PER MONTH
☐ 12 MONTHS $70.00 PER MONTH
PLUS $ 55.00 ONE TIME ENROLLMENT FEE
PLUS $100 SCREENING FEE FOR COMMUNITY MEMBERS

INDIVIDUAL MEMBERSHIP: PAID IN FULL
5% Discount for a 6 month term OR a 10% Discount for a 1 year term are applied
☐ 6 MONTHS $456.00
☐ 12 MONTHS $ 756.00
PLUS $ 55.00 ONE TIME ENROLLMENT FEE
PLUS $100 SCREENING FEE FOR COMMUNITY MEMBERS

*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.
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 refer to PURCHASERES RIGHT TO CANCEL under Membership Policies for more information.

X ____
Member Signature

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

==OFFICE USE===
Trans Listing___ Type___ Stat ___ JOIN___ Calen___ Exp ___ User____ Drft _____ CODE___ Repet____ Modify Rep___ Note____