The Burke Independent FES Cycling Program

Welcome and thank you for choosing Burke to make fitness a part of your life!

The Burke independent FES Cycling 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 cardiovascular and muscular stamina. Our staff has qualifications ranging from certifications by nationally recognized fitness agencies to doctorate degrees in physical therapy.

The Burke Independent FES Cycling Program is not physical therapy and medical insurance does not cover membership charges. It is a self-pay program.

All prospective members will be pre-screened by a Physical Therapist to determine eligibility. 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, **597 – 2122!** *We look forward to meeting you!*

The Burke Independent FES Cycling Program

RISK REVIEW AND PHYSICIAN APPROVAL FORM

Independent FES Cycling Program is a fitness program run through Burke Rehabilitation Hospitals Outpatient Physical Therapy Department, meant to target community members with neurological impairments. The program is independent, and includes a 60-90 minute session with a Physical Therapist to initiate and set up parameters on the cycle, and establish eligibility to participate in the program. The purpose of the program is to provide those with a neurological impairment from brain injury, SCI, or CVA a safe environment to independently reap the benefits of FES-assisted cycling.

Please review and sign the following health questionnaire if you feel this program is appropriate for your patient to attend.

STEP 1. ANSWER FOLLOWING QUESTIONS: STEP 2. HAVE PHYSICIAN SIGN BACK
IF YOU ARE NOT SURE ABOUT ANY QUESTION, PLEASE ASK YOUR PHYSICIAN.

NAME: _____ **PHONE:** _____ **Date:** _____

TABLE 1

RISK FACTOR	ACSM RISK FACTOR DEFINING CRITERIA	YES	NO	NOT SURE
1. 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)?			
2. CIGARETTE SMOKING	Are you a current cigarette smoker or have you quit within the previous 6 months?			
3. 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?			
4. HIGH CHOLESTEROL	Has your doctor prescribed medication to lower your cholesterol?			
5. FASTING GLUCOSE	Have there been any abnormal fasting glucose measurements on at least 2 separate occasions?			
6. OBESITY	Is your waistline over 40 inches if you are male or 35 inches if you are female?			
7. 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 THESE 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 that you can feel?			
Significant pain in 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?			
Episode of autonomic dysreflexia?			

The Burke Independent FES Cycling Program
RISK REVIEW AND PHYSICIAN APPROVAL FORM

NAME: _____ **PHONE:** _____ **Date:** _____

PHYSICIAN NAME:_____ **PHONE:**_____

PHYSICIAN SPECIALTY:_____

PHYSICIAN APPROVAL AND RECOMMENDATIONS
***TO BE COMPLETED BY YOUR PHYSICIAN**

POTENTIAL MODERATE RISK:
*MALE OVER AGE 45;
*FEMALE OVER AGE 55;
*2 OR MORE **YES** ANSWERS IN **TABLE 1.**

POTENTIAL HIGH RISK:
*1 OR MORE SYMPTOMS FROM **TABLE 2;**
*KNOWN CARDIOVASCULAR, PULMONARY OR METABOLIC DISEASE.

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 exercise = up to 3 METS; Moderate exercise = 3-6 METS; Vigorous exercise > 6 METS
Note: "moderate intensity" may be considered "hard" and "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's participation in the Burke FES exercise program, with the following guidelines/recommendations.

_____

_____

Physician Name:_____
Physician Signature: _____ ***Phone***_____

EXERCISE RESTRICTIONS (Optional).
☐ **PLEASE RESTRICT MY PATIENT FROM VIGOROUS EXERCISE.**

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

Thank you for helping us guide and encourage your patient to stay active!
The Burke Independent FES Cycling Program- Phone: 597-2122, Fax: 597-2763

HEALTH REVIEW

EXERCISE READINESS QUESTIONNAIRE	YES	NO
Are you over age 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 have a bone or joint problem such as arthritis that has been aggravated by exercise?		
Has your doctor ever said you have heart trouble?		
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 you ever had, or do you now have any of the following conditions?

	Date:		***Date:***
• **High Blood Pressure**	_____	• **Osteoporosis**	_____
• **Stroke**	_____	• **Arthritis**	_____
• **Congestive Heart Failure**	_____	• **Diabetes**	_____
• **Heart Attack**	_____	• **Cancer**	_____
• **High Cholesterol**	_____	• **Positive TB Test?**	_____
• **Aortic Stenosis**	_____	• **Peripheral Vascular Disease**	_____
• **Cardiovascular Surgery**	_____	• **Recent (1 year) fracture**	_____
• **Aneurysm**	_____	• **Pulmonary Hypertension**	_____
• **Cardiac Arrhythmia**	_____	• **Emphysema**	_____
• **Recent Surgery**	_____	• **Oxygen therapy Liters/m**	_____
□ **Parkinson's Disease**	_____	• **Do you smoke?**	_____
• **Autonomic Dysreflexia**	_____	• **Other**	_____

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

_____

When was most recent bone density scan? **DATE:** _____

Do you have a joint replacement? If yes, which joint has been replaced?

_____

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

_____

PLEASE SELECT ALL KNOWN HEALTH CONDITIONS THAT APPLY:

CARDIOVASCULAR

- ☐ 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 DEFRIBILLATOR

MUSCULOSKELETAL

- ☐ ANKLE SWELLING
- ☐ BACK PROBLEMS
- ☐ BROKEN BONES (RECENT)
- ☐ FIBROMYALGIA
- ☐ FOOT PROBLEMS
- ☐ LIMITED MOTION IN JOINTS
- ☐ LUPUS
- ☐ NECK PROBLEMS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ SHOULDER PROBLEMS
- ☐ SWOLLEN, SORE, PAINFUL JOINTS

PULMONARY

- ☐ ALLERGIES
- ☐ ASTHMA
- ☐ ASTHMA (EXERCISE INDUCED)
- ☐ BRONCHITIS
- ☐ CHRONIC RECURRING COUGH
- ☐ EMPHYSEMA
- ☐ PNEUMONIA
- ☐ PULMONARY EDEMA

OTHER

- ☐ ANEMIA
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ EPILEPSY or SEIZURES
- ☐ HEARING IMPAIRMENT
- ☐ PARKINSON'S
- ☐ POST-NATAL
- ☐ PREGNANT

OTHER CONDITION NOT LISTED ABOVE: _____

MEMBERSHIP POLICIES:

1. MEMBERSHIP DUES will be collected at the first orientation or screening for the upcoming membership (see types below). **The Burke Independent FES Cycling Program must be notified of ANY credit card changes immediately (i.e. new card, new account number, new expiration date, etc.)**

2. **MEMBERSHIP TYPES:**
   10 Rides: First package bought includes a new set of electrodes. All subsequent packages purchased, the member is responsible for the purchase of electrodes through provided suppliers. All rides must be used within a 2 month time period. Any rides remaining after this timeframe will be forfeited.
   20 Rides: First package bought includes a new set of electrodes. All subsequent packages purchased, the member is responsible for the purchase of electrodes through provided suppliers. All rides must be used within a 3 month time period. Any rides remaining after this timeframe will be forfeited.

3. CHECK-IN PROCEDURE: Upon entering The Burke Independent FES Cycling Program, all members are required to check in at the aide desk by providing punch card. If a member arrives to session without membership card, member may not be allowed to ride at discretion of supervising staff.

4. HOURS OF OPERATION: The Burke Rehabilitation Hospital reserves the right to change its Independent FES Cycling hours of operation for any reason. For example due to changes in member usage, maintenance repairs, community service activities, or holidays.

   M-TH 4:45-6:45
   Saturdays 9:30-12, 1:30-3

5. RATE CHANGE: Monthly rates and all policies of The Burke FES Cycling 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.

6. **FREEZE POLICY: You may freeze your membership for any reason (medical, vacation, etc). All freezes are for a minimum of one month and a maximum of three months. During this time you will be charged a $10 fee for each month your membership remains on freeze. If you use the freeze status during your commitment period, your contract 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.**

7. LOCKERS: We do not provide lockers at the Burke Independent FES Cycling Program. The program, its agents or employees shall not be liable for the loss, theft or for damage to the personal property of members. Members are urged not to bring valuables onto the premises.

8. 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.

9. **PURCHASER'S RIGHT TO CANCEL: IF YOU WISH TO CANCEL THIS AGREEMENT, YOU MAY CANCEL BY MAILING A WRITTEN NOTICE TO THE BURKE FITNESS CHALLENGE. THE NOTICE MUST SAY THAT YOU DO NOT WISH TO BE BOUND BY THIS AGREEMENT AND MUST BE MAILED BY MIDNIGHT OF THE THIRD BUSINESS DAY AFTER YOU SIGN THE AGREEMENT.** After you cancel, The Burke FES Cycling Program may request the return of all

agreements, and other documents of evidence of membership. The notice must be delivered or sent by certified mail to: The Burke Independent FES Cycling Program, 785 Mamaroneck Ave., White Plains, NY 10605. You may also cancel membership if you relocate your residence further than twenty–five miles from the facility and if upon a doctor's order, the consumer cannot receive the services as stated in the contract because of significant physical disability for a period in excess of six (6) months. 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.

10. **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.

11. **MEMBERS AGREE TO ACT IN ACCORDANCE WITH THE POLICIES OF THE BURKE INDEPENDENT FES CYCLING 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 exercise 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/performance.
    - Do not use the FES Cycle without prior instruction from staff.
    - Do not use the FES Cycle if it appears damaged or broken.
        - Please report any broken equipment to a staff member.
    - Members are responsible for keeping all appointments (orientations), and when they are unable to do so for any reason, notifying the program as soon as possible.
    - The 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.
    - Participants must be independent in equipment competency involved in setting self up in the RT300 OR if I require help from caregiver that I am independent from a caregiver that I am independent in directing my caregiver in proper procedures OR that he/she must be fully competent in equipment as well
    - I am responsible for making sound judgment in regards to my participation in regard to illness, skin breakdown, new pressure sores etc., and will contact physician as needed.

12. RULES OF CONDUCT:
    - Use all safety precautions.
    - 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**

FES Cycling Program Liability Waiver

I,_____wish to enroll in the Independent FES Cycling Program at The Burke Rehabilitation Hospital. I understand that exercising in this program involves exercising on a motorized exercise machine; 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 Independent FES Cycling 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 and autonomic dysreflexia. 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 Independent FES Cycling 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 this 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_____

THE BURKE INDEPENDENT FES CYCLING 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: _____/____/_____

FEES:

INITIAL SCREENING FEE: $200 (includes 2, 1 hour training sessions)

ENROLLMENT FEE: $55

# Sessions	Cost/Session	Total Cost
10	$22.50	$225
20	$20	$400

Electrodes may be purchased online at the following websites:
http://www.medi-stim.com/electrode.html - Pals Platinum Electrodes (3"x4" large, 2" x 3.5" small)
http://www.stimsource.com Pals Platinum Electrodes (3"x4" large, 2" x 3.5" small)
OPTION 2:

BILLING OPTIONS

1. CREDIT CARD BILLING

☐MASTERCARD ☐VISA ☐AMEX **CARD #** _____ **EXP. DATE** ____/____
CARD ISSUER _____ **NAME ON CARD** _____
1ST MONTH CHARGE - $ _____

REMAINING MONTHS - $ _____ **PER MONTH FOR** ☐ **FIVE** ☐**ELEVEN MONTHS.**

2. PAYMENT IN ADVANCE

ENCLOSED IS PAYMENT IN ADVANCE FOR _____**MONTHS. AMOUNT PAID = $**_____
AMOUNT PAID INCLUDES AN INITIAL ENROLLMENT FEE OF $_____,
CHECK # _____

☐MASTERCARD ☐VISA ☐AMEX **CARD #** _____ **EXP. DATE** ____/____
CARD ISSUER _____ **NAME ON CARD** _____

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_____ _____
Buyer/Member Signature Date