OSTC

Orthopaedic & Sports Therapy Center

Wichita Falls, TX
(940) 692-4688

Membership Agreement

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

(___)-_____-_____ (___)-_____-_____
Home Phone Cell Phone

E-Mail _____

In case of emergency contact: _____ Phone _____

The undersigned acknowledges that he/she desires to join the Orthopaedic and Sports Therapy Center and agrees to pay the OSTC Wellness for the right to use the center's facility and agrees to abide by all the rules set up by facility.

It is understood by the undersigned and he/she expressly agrees that all exercises, treatments, and the use of the facility including the swimming pool; where there will be no lifeguard on duty, shall be undertaken at the member's own risk. The member represents through the completion of a health history questionnaire that he/she is physically able to undertake any and all physical exercise provided by Orthopaedic and Sports Therapy Center. If the member is in doubt as to his/her physical ability to undertake such physical exercise, the member acknowledges that he/she has the duty of consulting with his/her physician prior to participation in wellness program. It is understood that the member expressly forever releases and discharges Othopaedic and Sports Therapy Center from all claims, injuries, damages, actions or causes of action, from all facts of active or passive negligence on the part of Orthopaedic and Sports Therapy Center, their servants, agents or employees.

Would you like to be contacted for free wellness orientation? Yes / No

Will you be using the pool and would you like to be placed on the aquatics contact list? Yes / No

_____ Date _____
Member's Signature

_____ Date _____
Parent's Signature (if member is minor)

Please Choose One:

☐ **Wellness Membership**
Month to Month Payments

By choosing to pay month to month for my Wellness Membership, I, _____ understand that I will need to pay for each month by the 10th unless other arrangements have been made. I will also fill out a cancellation form when I no longer wish to use the facilities. I also understand that I am responsible for payment regardless of membership usage.

☐ **Wellness Membership**
Auto Draft Payments

By choosing to pay by auto draft for Wellness Membership, I, _____ understand that I will be charged for each month and I am required to pay the fee unless a Cancellation Form is completed. Payments are withdrawn on the first of each month; therefore in order to stop my membership, I must submit my Cancellation Form by the 25th of the month. I also understand that I am responsible for payment regardless of membership usage.

Signature _____ Date _____

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Waiver of Claims
Wellness and Sports Conditioning Programs

It is expressly agreed that all use of equipment and facilities of Orthopaedic & Sports Therapy Center (OSTC), shall be undertaken at the risk of the participants. The activities of this program will be physically demanding and a risk of injury does exist. The undersigned shall agree to hold harmless the OSTC, Orthopaedic Associates, its trustees, employees, and agents. Any claim, demand, injury, expense or damages whatsoever, including and without limitations, those resulting whole or in part front the acts or omissions attributable to the agent, employees, or representatives are included.

The undersigned agrees that he/she has read and understands the terms and conditions of this agreement, and agrees to the terms and conditions.

_____ _____
Signature Date

_____ _____
Printed Name Date

_____ _____
Parent Signature (if participant is a minor) Date

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RULES & REGULATIONS

1. All fees must be paid in advance. There are no refunds.
2. If you have cardiac/pulmonary problems, high blood pressure, or other health problems, you must inform us prior to your membership.
3. You must wear athletic shoes and appropriate attire in the exercise area.
4. No drinking of alcoholic beverages before or during usage of the Wellness Center. No tobacco products are allowed. There will be no use of abusive or foul language.
5. No drinks are allowed on the carpeted areas. Bottled water is allowed in the weight equipment area and in the pool area.
6. OSTC is not responsible for personal items. All personal items must be either kept with you or left in a locker during your workout and taken with you at its conclusion.
7. Headphones must be used with all personal music.
8. Any out-of-town guest will sign a contract to release OSTC of any responsibility. The host member is responsible for showing his/her guest the proper use of the equipment.
9. A guest from the local area, who is considering becoming a member of OSTC wellness program is allowed two free visits, then they are required to purchase a membership before exercising again.
10. OSTC reserves the right to require a physician's consent prior to approval of membership. Failure to provide a physician's consent can result in denial of membership.

Pool Rules and Regulations

1. Clients must shower before entering the pool.
2. Emergency medication (asthma inhalers, nitroglycerin) must be brought to the pool each visit if the client has a condition that can be exacerbated by exercise.
3. Cutoffs and frayed clothing are not permitted in the pool. No horseplay or rough housing allowed in the water or on the deck.
4. No diving.
5. All clients must inform the staff prior to entering the pool of any of the following: open wounds, rash, urinary or fecal incontinence, allergies to pool chemicals, fear of water or severe weakness.
6. Any pool equipment that the client uses during their workout should be returned to its proper place when the client leaves the pool area.

As a member of the Orthopaedic and Sports Therapy wellness program, I agree to abide by all the rules presented. I realize that violation of any rule could result in my dismissal from the wellness center, and that if this occurs, my membership fee will not be refunded.

_____Date_____

Member's Signature

_____

Printed Name

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Health History Questionnaire

Date: _____ **Name:**_____ **Age:**_____

Answerer YES, NO, or UNKNOWN to all of the following questions:

1. **HIGH RISK FACTORS:**

   Do you smoke? _____ Is your cholesterol abnormal? _____

   Are you being treated for high blood pressure? _____

   Does your father, mother, brother, or sister have heart disease? _____
   If yes, state the age of onset:_____

2. **Are you pregnant?** _____

3. **DISEASES:**

   Are you currently under the care of a physician? _____
   If yes, for what condition? _____

   Do you have any of the following?

   Heart Disease _____ Diabetes _____

   Asthma _____ Emphysema _____

   Any additional diseases of physical conditions that might interfere with physical exercise:

   _____

4. SYMPTOMS

Have you ever experienced any of the following:

Chest pain _____

Unusual shortness of breath with exertion _____

Unusual weakness with exertion _____

Pain in arm, neck, jaw, or upper back with exertion _____

Indigestion or abdominal pain with exertion _____

Frequent dizziness or blackout spells _____

5. MUSCULOSKELETAL

Do you have any current problems with:

Shoulder _____

Knee _____

Other Joint _____

Back Pain _____

Herniated Disk in Back or Neck? _____

Other musculoskeletal problems: _____

_____

_____

6. MEDICATIONS:

List all medications that you regularly take (prescribed or non-prescribed):

_____

_____

_____

_____