APPLICATION FOR MEMBERSHIP

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◊ **Member Information** Referring Physician_____

Name: _____, _____, _____
(Last) (First) (Middle)

Driver's License #: _____ Sex: M /F: _____ Date of Birth:_____

Social Security #:_____ Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell #: (____) _____-_____

I understand my membership is in effect (whether I attend or not), and I am responsible for any unpaid balance through the date of termination of my 24_(__) /12 (__) month agreement. The imitation fee and membership fees paid are non refundable (whether I attend or not).

☛ Signature: _____ Date: _____

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For Office Use Only

Type

( ) Indoor Wellness Program ( ) 12 Month Agreement ($40.00/Month/**non-refundable**)
( ) Indoor/Pool Wellness Program ( ) 24 Month Agreement ($35.00/Month/**non-refundable**)

The date your membership begins: _____.
The amount of your initiation fee = $50.00/**non-refundable**

Deposit for access card: $_____ (Refundable when card is returned in good condition)

Staff Initials_____ Date_____

Comments: _____

_____

ANGELINA REHABILITATION CENTER, L.L.C.
✉ 402 S. John Redditt Dr. ◆ Lufkin, Texas 75904 ◆ ☎ (936) 632 2107 ◆ Fax: (936) 632 2108

MEDICAL PROFILE

Name: _____ Age:_____ Sex:_____

Primary Physician: _____Phone #: _____

In case of emergency contact_____ at Phone #_____

Relationship to contact: _____

PAST MEDICAL HISTORY

____ Rheumatic Fever	____Varicose Veins	____Injuries:	____Heart Trouble:
____Heart Murmur	____ Lung Disease	____Back	____ Coronary Heart Disease
____High Blood Cholesterol	____Diabetes	____Knees	____Myocardial Infarction
____High Blood Pressure	____Arthritis	____Ankles	____Rhythm Abnormalities
____Stroke	____Asthma	____Neck	____History in Family
____Overweight (20 lbs or more)	____Advise from Physician not to exercise		
	____ Other (explain: _____		

PRESENT SYMPTOMS

Check the appropriate box if you have recently experienced any of the following:

[ ] Chest Pain	[ ] Heart Palpitations	[ ] Cough on Exertion
[ ] Back Pain	[ ] Lightheadedness	[ ] Shortness of Breath

If you have had a recent operation please explain what type and how recent: _____

_____

RISK FACTORS

1. Do you smoke? ____Yes ____No ____Quit (____Cigarettes ____Cigars ____Pipe)
2. Are you presently taking any medications? ____Yes ____No
   If yes, please list the medication and reason for taking:
   _____

   _____
3. Have you ever had a stress test (graded exercise E. K.G.)? ____Yes ____No

   Would you be interested in one? ____Yes ____No

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RELEASE OF LIABILITY

Release of Liability Statement for Use of Exercise Equipment

I, _____, hereby release ANGELINA REHABILITATION CENTER from all liability associated with the use of any and all exercise equipment owned by ANGELINA REHABILITATION CENTER regardless of location. I acknowledge that I will operate said equipment in a safe manner following the manufacturer's recommendation for use and notify the ANGELINA REHABILITATION CENTER staff of any equipment malfunctions which occur while I am using it.

Further more, I acknowledge that I have a personal exercise program that does not require the staff involvement. I further acknowledge that my utilization of the exercise equipment will be on a 'space and time available' basis so to not interfere with ANGELINA REHABILITATION CENTER program

_____	_____	_____
Signature of Patient/Guardian	Date	Signature of Witness

_____	_____
Print Name of Patient/Guardian	Print Name of Witness

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AGREEMENT

12/24-Month Addendum Agreement

1. This membership (see attached Contract) is for a minimum of

   [] (12) months $40.00_____ (initial)

   [] (24) months $35.00_____ (initial)

   $50.00 application fee – one time fee

After which the membership becomes a month to month, **requiring a minimum of thirty (30) days written cancellation. _____ (initial)**

2. **Non-use of client does not negate monthly payments.** The twelve (12) or Twenty four (24) month period is **over and above any non-pay period** which may or may not be a part of this agreement, _____ (initial)

3. Membership may be terminated on or before the first of the twelfth (12th) or twenty fourth (24th) **paying** month of this agreement by delivering a thirty (30) day written notice to Angelina Rehabilitation Center. **No verbal termination will be acceptable; it must be put in writing and either hand delivered or mailed within the specified time limit.** In the event notice is delivered, the initial Contract shall continue on a month to month basis and all other terms and conditions of the initial Contract shall remain in full force and effect.____(initial)

4. If membership is payroll deducted, this contract will be in effect **even if I am no longer employed at the company** where the payroll deduct originated. I will be billed at home or bank drafted for the duration of this contract. _____ (initial)

I completely understand the duration of this contract. I must pay for twelve (12) or twenty four (24) months as indicated above of the initial Contract and the Termination Policy and will abide accordingly. I also understand that should I decide to cancel this contract early, there is a buy out fee of $15 per month remaining on the contract.

_____ ☛ _____

Member Signature:

_____ _____

Staff Date

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RECURRING PAYMENT AUTHORIZATION FORM
ACH DEBIT/BANK DRAFT

If you would like to enjoy the convenience of automatic recurring billing, simply complete the bank Information section below and sign the form. All requested information is required. Upon approval, we will automatically debit your bank account for the amount indicated and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

Customer Information:

Customer/Company _____

Contact Name _____ Account Number _____

Email Address _____ Phone (_____) _____-_____Ext:_____

Payment Information

I authorize **ANGELINA REHABILITATION CENTER** to automatically debit my bank account listed below as specified

Product/Service Description _____

Recurring Amount _____

Frequency ☐ Once ☐ Daily ☐ Weekly ☐ Twice/Month ☐ Monthly ☐ Quarterly
(Check one)

Start on _____/_____/_____ End on: ☐ _____/_____/_____
Month Day Year (Check one) Month Day Year

☐ No End Date

Bank Information (To be completed by Customer**)**

Bank Institution Name: _____

Bank Routing # _____ Bank Account # _____

Type of Account ☐ Checking ☐ Savings.

☐ Notify me via email when my Credit card is charged. (Make sure email address above is correct.)

Please attach avoided check for account for verification purposes

☞_____ _____
Customer's signature **Date**

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RECURRING PAYMENT AUTHORIZATION FORM
CREDIT CARD

If you would like to enjoy the convenience of automatic recurring billing, simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

Customer Information:

Customer/Company _____

Contact Name _____ Account Number _____

Email Address _____ Phone (_____)_____-_____Ext:_____

Payment Information

I authorize _____to automatically bill the card listed below as specified

Product/Service Description _____

Recurring Amount _____

Frequency ☐ Once ☐ Daily ☐ Weekly ☐ Twice/Month ☐ Monthly ☐ Quarterly
(Check one)

Start on _____/_____/_____ End on: ☐ _____/_____/_____
Month Day Year (Check one) Month Day Year

☐ No End Date

Credit Card Information (To be completed by Customer**)**

Card type ☐ Master Card ☐ Visa ☐ Discover ☐ Amex ☐ other _____

Cardholder Name _____ Cardholder ZIP Code_____
(As shown on card) (From credit card billing address)

Card Number _____ Expires _____/_____

☐ Notify me via email when my Credit Card is charged. (Make sure email address above is correct.)

☞_____ _____
Customer's signature **Date**

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