Demographics/Medical History

Demographics Information

Date _____First Name _____Last Name _____

Date of Birth _____Age _____Gender ☐ Female ☐ Male

Street _____ City _____

State_____ Zip Code _____

Phone number: _____Cell Phone: _____Email: _____

Emergency Contact Name _____Emergency Phone_____

What was your motivation for joining UMedGym? _____

How did you hear about us? _____

Primary Insurance Provider _____ Secondary Insurance Provider_____

Guardian (if applicable)_____ Relationship to Member_____

PHYSICIAN RELEASE FORM

***PLEASE READ:* List Physicians you would like us to send quarterly letters to regarding your biometric and fitness data. You may opt out by checking the box below or at any time by providing written notice.**

*Primary Care Physician*_____

Address/Medical Group_____

Phone Number _____Fax_____

*Other Physician*_____Area of Practice_____

Address/Medical Group_____

Phone Number _____Fax_____

Other Physician _____Area of Practice_____

Address/Medical Group_____

Phone Number _____Fax_____

OR Opt Out: ☐ I DO NOT want my biometric and fitness data sent to my providers. (Do not complete fields above)

By signing, I authorize the release of medical information to/from the above physician (s)/specialist (s) regarding my own, my dependent's or my child's medical information unless opt out is indicated.

Signature_____ ☐ Guardian ☐ Self

Do you have a DNR (do not resuscitate) order? ☐ Yes ☐ No

Please check all conditions or diagnosis that apply (includes current and past medical conditions):

- ☐ Abnormal EKG
- ☐ Abnormal chest x-ray
- ☐ Rheumatic fever Chronic
- ☐ Low blood pressure Persistent fatigue
- ☐ Asthma Stomach
- ☐ Emphysema Hernia
- ☐ Other lung problems:_____
- ☐ Limited ROM Foot
- ☐ Arthritis Knee
- ☐ Bursitis Back
- ☐ Broken bones:_____
  _____
- ☐ Joint pain or swelling:_____
  _____
- ☐ Epilepsy or seizures: Meds.:_____
  Last episode:_____
- ☐ headaches/migraines
- ☐
- ☐ problems:_____
- ☐
- ☐ Anemia
- ☐ problems:_____
- ☐ problems:_____
- ☐ problems:_____
- ☐ Shoulder problems:_____
  Previous surgeries: _____
  _____
- ☐ Other:_____

QUESTION 1: Please check all that apply regarding a your medical history - You have had:

- ☐ Heart attack Cerebrovascular
- ☐ Cardiac catheterization
- ☐ Coronary angioplasty (stent)
- ☐ Pacemaker/implantable defibrillator
- ☐ Metabolic disease (diabetes
- ☐ Rhythm disturbance disease)
- ☐ Heart valve disease Known
- ☐ Heart failure None of the above
- ☐ disease
- ☐ Peripheral vascular disease
- ☐ Pulmonary disease (COPD, cystic fibrosis, interstitial lung
- ☐ disease, emphysema)
- type I or type II, kidney or liver
- ☐
- ☐
  cardiovascular disease

Heart transplantation

Congenital heart disease

Date of your event(s) or diagnoses: _____

QUESTION 2: Do you currently experience any of the following (check all that apply):

- ☐ Chest discomfort with exertion
- ☐ Unreasonable breathlessness
- ☐ Dizziness, fainting or blackouts
- ☐ Swelling in your ankles or lower extremities (edema)
- ☐ Heart palpitations or fast heart rate at rest (>100bpm)
- ☐ You take heart medications
- ☐ None of the above

When was your most recent episode:

_____

QUESTION 3: Do you currently have any of the following: You have

- ☐ Pre-diabetes (elevated A1C)
- ☐ You have asthma or lung disease
- ☐ You have burning or cramping sensations in your lower legs when walking short distances
- ☐ You have musculoskeletal problems that limit your physical activity
- ☐ You have a known heart
- ☐ murmur

None of the above **QUESTION 4**: Please check off all that apply:

- ☐ You are a man older than 45 years old You
- ☐ don't know your cholesterol level
- ☐ AND have had a hysterectomy OR are postmenopausal
- ☐ heart surgery before the age of 55 OR your mother or sister had a heart attack or heart surgery before age 65 You are a woman older than 55 years old Your father or brother had a heart attack or
- ☐ You smoke or quit smoking within the previous 6 months You are physically inactive
- ☐ (i.e. you get less than
- ☐ Your blood pressure is >140/90 mmHg 30
- ☐ minutes of physical activity <3 days/week
- ☐ You take blood pressure medication You are
- ☐ >20 lbs overweight Your blood cholesterol level is >200mg/dL None of the above

Has your mother, father, or siblings suffered from any of the following conditions:

- ☐ Stroke prior to age 50
- ☐ Congenital heart disease or left ventricular hypertrophy
- ☐ Hypertension
- ☐ Leukemia/cancer prior to age 60
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Obesity
- ☐ Asthma
- ☐ Osteoporosis
- ☐ I don't know my family history
- ☐ None of the above

_____

Please indicate any other medical conditions or activity restrictions that you may have that has not been addressed:

_____

_____

_____

_____

Please rate your daily stress level:

- ☐ Low
- ☐ Moderate
- ☐ High (but I enjoy the challenge)
- ☐ High (but sometimes difficult to handle)
- ☐ High (often difficult to handle)

Do you drink alcoholic beverages? ☐ Yes ☐ No

Approximate number of drinks per week? _____

Please select all that apply regarding your dietary habits:

- ☐ I seldom consume red or high fat meats
- ☐ I eat at least 5 servings of fruit and veggies per day
- ☐ I pursue a low-fat diet
- ☐ I almost always eat a full healthy breakfast
- ☐ My diet includes many high fiber foods
- ☐ I rarely eat high sugar or high fat desserts

Do you make yourself sick because you feel uncomfortably full? ☐ Yes ☐ No

Do you worry you have lost control over how much you eat? ☐ Yes ☐ No

Have you recently lost more than 14lbs in a 3 month period? ☐ Yes ☐ No

Do you believe yourself to be fat when others say you are to thin? ☐ Yes ☐ No

Would you say that food dominates your life? ☐ Yes ☐ No

Fitness and Lifestyle Goals

Physical Activity History: _____

_____

Recreational/Social Interests:_____

_____

Medication List

Name:_____

Prescription: Dose: Frequency:

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10.

_____

Supplements: Dose: Frequency:

1. _____

2. _____

3. _____

4. _____

5. _____

Ready to Change Questionnaire: Please Rate the Following

(1 = Not interested 9 = Interested)

1.) Your level of interest in participating in a fitness?

1…..2…..3…..4…..5…..6…..7…..8…..9

2.) Are you ready for lifestyle changes as part of your fitness program?

1…..2…..3…..4…..5…..6…..7…..8…..9

3.) How much support can your family provide?

1…..2…..3…..4…..5…..6…..7…..8…..9

4.)How much support can your friends provide?

1…..2…..3…..4…..5…..6…..7…..8…..9

5.) How confident are you that you can regularly participated in exercise?

1…..2…..3…..4…..5…..6…..7…..8…..9

Total Score_____ Divided by 5 = Ready to Change Score_____

PHYSICIAN GUIDELINES:

 Do you have blood pressure guidelines as specified by your physician? ☐ Yes ☐ No

 Please indicate acceptable resting blood pressure for you to initiate exercise without physician notification (any blood pressure documented above this value warrants physician notification and clearance to continue exercise): ____/_____

 Do you have blood glucose guidelines as specified by your physician? ☐ Yes ☐ No

 Please indicate acceptable pre-exercise blood glucose level (any blood glucose level documented above this value warrants physician notification and clearance to continue exercise):

_____

 Has your physician specified any other guidelines or limitations? ☐ Yes ☐ No

 Please describe additional physician guidelines:

_____

_____

_____

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this Privacy Notice

- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

We may use and share your information as we:

- Treat you and design your plan of care
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Work with students and interns
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- We do not sell or market personal health information.

Get a copy of this Privacy Notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you *(space provided on the last page for this information)*

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, **please submit instructions to The M.O.G. in writing**. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Decline authorization to allow students and interns to work with/observe you

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Work with you and Design your plan of care

We can use your health information and share it with other professionals as well as students and interns who are working with you, observing and designing your plan of care (personalized strength and conditioning program, etc.).

Example: A clinical trainer working with you for an injury/disease/disability asks another clinical trainer about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research, studies, and pilot programs which includes but is not limited to communication with students, interns and other professionals involved.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

PLEASE COMPLETE: INSTRUCTIONS ON SHARING YOUR HEALTH INFORMATION

Select One:

I do not want any information about my healthcare communicated to family members/caregivers.
I give UMedGym permission to verbally communicate to family members/caregivers listed below.

Name:_____ Name:_____ Name:_____

Please check the box next to the specific information that may be **verbally** communicated to the individual(s) listed above:

- ☐ All information regarding my membership, healthcare and care under UMedGym
- ☐ Check in Regarding Health/Medical Status
- ☐ Request/Confirm/Cancel Appointments
- ☐ Membership Status
- ☐ Medical Clearance
- ☐ Physician Contact
- ☐ Payments
- ☐ Other (specify):

_____

Choose Someone to Act for You

I choose someone who has Medical Power of Attorney to act for me and will provide UMedGym with a copy of the Power of Attorney.

Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zipcode:_____

COPY OF P.O.A. PROVIDED? UMedGym Staff Initials:_____

I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date, but will present further release of information.

I understand that my full name will be used for my Personal Exercise Folder located in public view for my personal ease of access and may contain information such as my blood pressure, heart rate and other vital signs and that I may decide at any time by submitting in writing that I wish for my Exercise Folder to be kept in a private area which may require restrictions on when I am able to exercise due to staff member's availability to access my file.

I have read and understand UMedGym's HIPAA Privacy Notice and authorize by signing below.

Print Patient Name:_____

Patient Signature: _____Date: _____

Parent/Legal Guardian or Representative Signature: _____ Date: _____

If there are any questions, you may contact Adam Hanrahan, Privacy Officer at ahanrahan@umedgym.com

UMedGym™ POLICIES AND AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

EXPECTATIONS OF STAFF At UMedGym, we are here to help guide you through proper exercise, injury prevention, health management and to facilitate care throughout the lifetime of your stay with us. However, our memberships do not include individualized attention with an athletic trainer every visit beyond your scheduled appointments. Our Athletic Trainers are actively surveying the gym floor during business hours to ensure safety and help correct technique as necessary.

MEMBER EXPECTATIONS If you have questions, concerns or issues, we trust that you will make us aware as we are unable to always pick up on every movement, discomfort or problem as you are exercising on your own. **If at any time you feel like you are not receiving the care that you believed you would receive as a member of UMedGym, we strongly encourage you to voice your concerns.** Please contact Amy Smith, Director of Member Care asmith@umedgym.com or by calling (207) 347-3030.

MEMBERSHIP SUSPENSION *Suspensions may be granted for Medical Reasons only:* **Surgery | Serious injury/illness** And must satisfy all of the following:

- ✓ 3 months minimum initial commitment
- ✓ Notify UMedGym prior to or immediately following the incident
- ✓ Requires physician's note indicating the length of time (min. of 30 consecutive days) in which the member is unable to be physically active
- ✓ We may require you to meet with your UMedGym Athletic Trainer prior to granting a suspension

If the reason qualifies, suspension may be accepted but *no refund*. A *Suspension Request* may be submitted with a doctor's note for anything outside of the above qualifications for extenuating circumstances.

MEDICAL CLEARANCE UMedGym reserves the right to require a physician's clearance prior to beginning/returning to exercise at UMedGym for the following scenarios and is not meant to penalize the member. We may also require a consultation with your Athletic Trainer prior to returning.

- Emergency visit to a physician's office, urgent care and/or hospital/emergency room
- Non-routine visit with a physician
- Absence due to diagnosis related concern
- Absent for 2 weeks or more and/or returning from membership suspension
- Any other concern that UMedGym staff deems appropriate to your care and safety at UMedGym.
- For NEW MEMBERS: the start of your exercise program may be put on hold for your safety as determined in your Initial Evaluation. Your membership begins on the date of your Initial Evaluation. If your physician refuses to clear you for exercise, a service fee of $75.00 will be charged for each appointment.

In any event, please notify UMedGym as soon as possible by calling (207) 347-3030.

NO SHOW/LATE CANCEL We reserve the right to charge for no shows without 24 hours notice. This does not apply to Medical Member Group Classes. Please arrive 15 mins before any appointment. If you are more than 10 mins late we reserve the right to charge a No Show Fee should we need to reschedule.

- Appointments will be charged a $25.00 Fee
- Classes will be charged the full class amount

MEMBERSHIP COMMITMENT Initial enrollment requires a minimum of 3 months consecutive membership commitment. After initial 3 months membership, member may choose to pay in full for an additional 3 months consecutive membership or pay via auto pay on a consecutive monthly basis. If membership lapses for any length of time, a minimum of 3 months commitment is reinstated.

NO REFUNDS

We reserve the right to change these policies without notice.

I have read and understand the policies and agreements and authorize my acknowledgment and compliance by signing below.

Signed:_____ **Print Name:**_____ **Date:**_____

United Medical Gym™ 125 John Roberts Rd, Suite 16 South Portland, ME 04106

Fee for Services Auto-Pay Authorization

I, _____ *(Please Print)* authorize United Medical Gym to withdraw fees associated to services provided to me by the method indicated below and post it to my membership account in the event that I have left a balance of unpaid service(s). I am aware that at any point in time I may request records of any/all charges and that all payments are due at the time of service.

I understand that I may revoke this authorization at any time by providing United Medical Gym written notice and that I will continue to be held responsible for providing payment of fees associated to services provided to me at the time of service.

I understand that if the below account information changes, I am responsible for notifying United Medical Gym before the change occurs if I am aware or immediately following my knowledge of the change of account information.

Please select your payment method below:

☐ *Checking*

Bank Name_____

Account #:_____

Routing #: _____

☐ *Credit Card (Visa, Discover or MasterCard)*

Authorized Signature_____ Date _____

THE FOLLOWING IS A WAIVER. PLEASE READ IT BEFORE SIGNING

BY AFFIXING MY SIGNATURE TO THIS DOCUMENT, I UNDERSTAND AND AGREE THAT I AM LEGALLY BOUND BY ITS CONTENTS.

Because physical exercise can be strenuous and subject to risk of serious injury, United Medical Gym urges you to obtain a physical examination from a doctor before using any exercise equipment or participating in any exercise activity. You (each member, guest, or participant) agree that if you engage in any physical exercise or activity United Medical Gym and SB Realty's amenities or access the professional services of United Medical Gym on the premises or off premises including any sponsored event, you do so **entirely at your own risk.** You agree that you are voluntarily participating in the use of this facility, equipment, activity, or services **and assume all risks** of injury, illness, or death. We are also not responsible for any loss of your personal property.

This waiver and release of liability includes, without limitation, all injuries which may occur as a result of: (a) your use of all amenities and equipment in the facility or the use of the same off-site and your participation in any activity, class, program, personal training or instruction, whether at United Medical Gym or off-site; (b) the sudden and unforeseen malfunctioning of any equipment; and (c) your slipping and/or falling while in or on the premises, including adjacent sidewalks and parking areas, other than injuries arising solely due to our gross negligence or willful misconduct.

You acknowledge that you have carefully read this "waiver and release" and fully understand that it is a **release of liability.** You, for yourself and your heirs, personal representatives, successors and assigns, expressly agree to release and discharge United Medical Gym and SB Realty and all affiliates, directors, members, managers, employees, agents, successors or assigns from any and all claims or causes of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against United Medical Gym and SB Realty for negligence, personal injury or property damage, other than injuries arising solely due to our gross negligence or willful misconduct.

You, for yourself and your heirs, personal representatives, successors and assigns, agree to indemnify United Medical Gym and SB Realty, and to hold them harmless for any claims made against them or their affiliates, directors, members, managers, employees, agents, successors or assigns in breach of this waiver, including their costs of court and reasonable attorney's fees.

ADDITIONAL AUTHORIZATION FOR MINOR TO PARTICIPATE WITHOUT PARENTAL/GUARDIAN PRESENCE

I wish to authorize the below named child/minor (age 14-18yrs) to participate at United Medical Gym either independently or with a clinical trainer without my (guardian's) presence and understand that United Medical Gym reserves the right to revoke if the conduct is unsuitable to the needs of others at any time. **Initials**_____

NOTE: Should any part of this agreement be found by a court of law to be against public policy or in violation of any state statute or case precedence, then only that wording is removed and the remainder of this agreement will remain in full force.

Signed:_____ Print Member's Name:_____

Circle One: Self **|** Guardian

Guardian's Name (if under 18yrs): _____Date:_____