

The Exer**Science** Center

MEMBERSHIP AGREEMENT AND ACKNOWLEDGEMENT OF RISK

Name (print legibly, please): _____
LAST FIRST

Phone Number: _____ E-Mail: _____

Home Address: _____

DOB: _____ Emergency Contact: _____

MEMBERSHIP TYPE

Best Self - Physical Therapy/Personal Training Memberships:

- \$600 Monthly Auto Renewal / 3 months commitment or
- \$7200 and get 1 additional month free
- Additional sessions for \$100/session up to one hour

Online ONLY Physical Therapy/Personal Training Memberships:

- \$600 Auto Renewal every 6 months or \$100 monthly with 1 year commitment
- Additional for \$55/session up to 30 minutes

Self-Driven Biohacker:

- \$200 Monthly Auto Renewal / 1 year commitment or
- \$2400 and get 1 additional month free

Halotherapy Salt Cave and Infrared Sauna Only:

- \$90 Monthly Auto Renewal / 1 year commitment or
- \$1080 and get 1 additional month free

Maintenance – Best Self Graduates:

- \$99 Month Auto Renewal w/ 1 year commitment or \$1188 and get 1 additional month free
- Additional treatments for \$125/session up to one hour

Wellness Plan:

- \$129 Month Auto Renewal w/ 1 year commitment or \$1548 and get 1 additional month free
- Additional treatments for \$125/session up to one hour

Ultimate Beast Mode:

- \$1111 Monthly Auto Renewal / 1 year commitment or
- \$13,332 and get 1 additional month free
- Additional sessions for \$100/session up to one hour

MEMBERSHIP AGREEMENT

_____ I agree to a recurring payment of the membership fee to be charged based on the membership type. Auto Renewal will be charged on the same day of sign up.

_____ Minimum of 3 months commitment. Note the attached cancellation policy below, also available on our website.

_____ A cancellation form submitted within at least 10 business days before your next billing date should result in no further recurring billing. If less than 10 business days, you will be billed one more time. At which time will be considered your final services available.

_____ Members may suspend their memberships for 3 months for a fee of \$10 per month. If the next billing date is within 10 days, the freeze is effective for the following month's billing. When you decide to "unfreeze" your membership, your auto renewal date will begin the day you agree to restart your program.

_____ Freezing an account past 3 months will result in termination of the membership and removal from our billing system. New members sign-up fee and different membership fees may apply based on current promotions.

_____ I understand an appointment and check in is required for admittance each time I visit.

_____ I have read and will comply with the late, no-show and cancellation policy.

_____ I have read and understand The ExerScience Center's policies, which is also available to me on their website – theexersciencecenter.com

_____ I also understand that my membership may be suspended or terminated at the discretion of Fitness Center Management.

_____ \$25 sign up service fee and 3% added for processing fee.

_____ A fee of \$100 for all Early Terminations of the membership agreement.

Signature: _____

Date: _____

Print Name: _____

HEALTH HISTORY AND SELF-ASSESSMENT

If you answer YES to any of the following questions, please contact your physician and obtain clearance before proceeding with any wellness program.

Has your doctor ever said that you have a heart condition and/or that you should only perform physical activity recommended by a doctor?

Do you feel pain in your chest during physical activity?

Do you lose your balance because of dizziness or do you every lose consciousness?

Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Is your doctor currently prescribing any medication for your blood pressure, cholesterol level, or a heart condition?

Are you diabetic?

Do you have a respiratory condition such as asthma, bronchitis, or emphysema?

Are you epileptic or do you experience seizures?

Are you currently taking any prescription medications that would limit your participation in an Exercise program?

Has your doctor advised you for any reason that you should not engage in an exercise program?

FINANCIAL POLICY

Patient Name: _____ Date: _____

The ExerScience Center and affiliated companies, collectively known as “The ExerScience Center”, are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- ALL PATIENTS MUST COMPLETE OUR “NEW CLIENT FORM” BEFORE STARTING SERVICE.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER, AND ZELLE.
- THE EXERSCIENCE CENTER PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minors Accompanied By An Adult

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at the time of service.

Unaccompanied Minors

The parents or guardians are responsible for full payment at the time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$25.00.

Missed Appointments

No-shows and late cancellations without 24 hour notice will be charged the full cost of the scheduled appointment. Do not email schedule changes or cancellations. This will be your responsibility; insurance cannot be billed for this amount. This fee must be paid prior to being seen for your next appointment.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ Date: _____

CARD ON FILE: Agreement to charge card

Account Number: _____ Exp. Date: _____ CVV : _____
Mo. Yr.

Name on Card: _____

Card Holder Signature: _____

KNOWLEDGEMENT OF RISK AND CONSENT

I understand that by signing this document I am representing that I understand all of its terms and conditions and that I fully intend to be bound by the same. I also understand that I may wish to consult with my attorney prior to signing this document. In consideration of being allowed to use The ExerScience Center's Fitness Center ("facility"), and/or participate in recreational programs or classes sponsored or offered by the facility, I hereby voluntarily execute this Acknowledgement of Risk and Consent Form. I represent that I am at least eighteen years old and competent to sign this form.

I understand that there are certain dangers, hazards and risks associated with my use of the facility and the equipment located therein ("the equipment"). I further understand that all risks cannot be prevented. In light of the risks associated with the use of the facility and its equipment, I may wish to consult with a physician or other health care provider regarding my current physical and mental fitness prior to beginning any physical fitness workout or regimen. I represent that I am physically and mentally able to use the facility and its equipment in a safe manner.

As a user of the facility, I shall follow all applicable facility policies and procedures and comply with all directives issued by the facility staff. I agree to refrain from the use of offensive or inappropriate language, wear appropriate exercise attire, use the equipment in accordance with its intended use, and respect the individual privacy of others utilizing the facility. I understand that a violation of any facility policies or procedures may result in disciplinary action up to and including suspension or expulsion from the facility.

I represent that I am covered by adequate medical/health/accident insurance for any injury that I may suffer while using the facility. In the event I must be transported to a doctor or hospital for medical treatment, I acknowledge that The ExerScience Center will not be obligated to provide such transportation, nor assume any responsibility for such transportation.

On Behalf of myself, my family, and my heirs, I hereby agree to assume all risks associated with my use of the facility and its equipment, and I hereby release and discharge from liability and waive any legal action against The ExerScience Center, its governing board, officers, agents and employees (collectively, "the released parties") for any personal injury, death, or property damaged I may suffer, due to any cause, including but not limited to the negligence of the released parties, arising out of or in any way connected to my use of the facility and/or its equipment.

I understand and agree that this document shall be construed in accordance with the laws of the Commonwealth of Florida. If any term or provision of this document shall be held invalid or unenforceable, the remaining terms and provisions shall remain in full force and effect.

Signature: _____

Date: _____

Print Name: _____

IN OFFICE ONLY

Witness: _____ Start Date: _____ End Date: _____

Notes: _____