

Select Therapy and Fitness

Name _____ Address _____
(street) (Apt #)

(City) (State) (Zip code) (Birthdate) (Home Phone) (Work Phone)

Initial Payment: Amount paid: \$ _____ Source of payment, please circle: Cash Check Credit Card Bank Draft
Effective Starting Date: _____ If starting after the 15th of the month, please collect 1/2 month dues for that first month, plus the next month's dues.

MEMBERSHIP AGREEMENT

Acct# _____

Terms of membership are a \$ _____ initial fee.
Single monthly fee of \$ _____ or pre-paid fee of \$ _____ for # _____ months.
Couple monthly fee of \$ _____ or pre-paid fee of \$ _____ for # _____ months.
Please provide name of the person you are doing a couple membership with: _____
Family monthly fee of \$ _____ or pre-paid fee of \$ _____ for # _____ months.
Please provide names of the family members who are joining with you: _____
Senior citizen monthly fee of \$ _____
College monthly fee of \$ _____ or pre-paid fee of \$ _____ for # _____ months.
Six (6) week student program (under 18): Fee paid of \$ _____ for # _____ weeks.
You are obligated to fulfill a **three (3) consecutive month membership status** (with the exception of the 6 week student program). The initial membership fee and first month fee must be paid in full on your initial evaluation (anniversary) date. _____ (please initial)

Putting you Membership on Hold: After fulfilling a **three (3) month contract**, (exception: 6week student program) only then can you put your membership on hold. Membership can be put on hold on a month-to-month basis. We must be **notified in writing by the 1st of the month** that you wish to go on hold, otherwise you will be liable for that month's dues. _____ (please initial)

Termination of Membership: A **three (3) month contract** (Exception: 6 week student program) must be fulfilled before termination of your membership. **A written notice must be received by us, from you, before the 1st of the month that you wish to terminate**, otherwise you will be liable for that month's dues. All past due membership fees and Juice Bar fees must be paid in full upon termination. _____ (please initial)

Refund: Refunds are only possible in the following instances: death, permanent disability, or moving greater than 50 miles from the Select Therapy and Fitness Center. Verification of all three instances is needed. _____ (Please initial)

Signature

Date
RELEASE FORM

The fitness and wellness program is not a substitute in any way for a physical examination by a physician. In order to determine and achieve personal fitness, the undersigned voluntarily requests the right to participate in the fitness and wellness program being offered by Select Therapy and Fitness.

The initial evaluation assessment will consist of the following components: posture, joint clearing, flexibility, body fat and physical work capacity tests. The physical work capacity test will be the most demanding test conducted on a stationary bike, for a submaximal effort. The amount of effort or workload will gradually increase during the test. Your heart rate and blood pressure will be monitored during the test. The test can be terminated at any point. Skin fold calipers will be used for body fat assessment.

A portion of the assessment will consist of you filling out a personal history form, a stress assessment form, and nutrition assessment and a cardiac risk profile.

If a private physician and/or consulting physician is involved in the program, I hereby authorize the physician involved to discuss with those responsible for the exercise program any aspects of my medical history and/or examination which may be appropriate or necessary for my evaluation and/or participation in the program.

I the undersigned do hereby authorize the Select Therapy and Fitness to furnish a report of the findings, evaluation and exercise report and all tests to my personal physician upon request. The statistical and scientific information obtained may be used as a means of acquiring research data.

The evaluation assessment has been explained to me by my instructors and any questions have been answered to my satisfaction. Potential risks and hazards to me in the program have also been explained to me by my instructors.

I wish to participate in the program and in consideration of the fitness and evaluation upon me I hereby release and hold harmless the staff of the Select Therapy and Fitness together with all of its agents, employees, officials from any or all liability, claims or suits, known or unknown arising in or out of any manner connected with my participation in the program at the Select Therapy and Fitness and the consequences thereof.

I have carefully read and understand the above information.

Signature _____ Witness _____ Date _____

Select Therapy and Fitness Contract (for Corporate memberships only)

Name _____ Address _____ Apt# _____
City _____ State _____ Zip _____
Home phone _____ Work phone _____
Birthdate _____ **Company/Corporate Name: _____

Initial Payment: Amount paid: \$ _____ Source of payment, please circle: Cash Check (# _____) MC or Visa

Effective Starting Date: _____ If starting after the 15th of the month, please collect 1/2 month dues for that first month, plus the next month's dues.

MEMBERSHIP AGREEMENT

Acct# _____

Terms of membership are a \$ _____ initial fee.

Single monthly fee of \$ _____ /month for 12 months. (\$25/one person)

*Family monthly fee of \$ _____ /month for 12 months. (\$35/couple; 3-5 more family members \$5 for each)

Please provide names of the family members who are joining with you: _____

You are obligated to fulfill a twelve consecutive month membership with no hold option. _____ (please initial)

After fulfilling a **twelve (12) month contract**, only then can you put your membership on hold. Membership can be put on hold on a month-to-month basis. We must be **notified in writing by the 1st of the month** that you wish to go on hold, otherwise you will be liable for that month's dues. _____ (please initial)

The initial membership fee and first month fee must be paid in full on your initial evaluation (anniversary) date. _____ (please initial)

Each additional monthly fee must be paid in full by the 10th of the month with no lapse in payment. _____ (please initial)

If you move more than 50 miles away from the fitness facility, your membership can be terminated. _____ (please initial).

*Family member living at the same address

Signature

Date

RELEASE FORM

The fitness and wellness program is not a substitute in any way for a physical examination by a physician. In order to determine and achieve personal fitness, the undersigned voluntarily requests the right to participate in the fitness and wellness program being offered by the Select Therapy and Fitness.

The initial evaluation assessment will consist of the following components: posture, joint clearing, flexibility, body fat and physical work capacity tests. The physical work capacity test will be the most demanding test conducted on a stationary bike or treadmill, for a submaximal effort. The amount of effort or work load will gradually increase during the test. Your heart rate and blood pressure will be monitored during the test. The test can be terminated at any point. Skin fold calipers will be used for body fat assessment.

A portion of the assessment will consist of you filling out a personal history form, a stress assessment form, and nutrition assessment and a cardiac risk profile.

If a private physician and/or consulting physician is involved in the program, I hereby authorize the physician involved to discuss with those responsible for the exercise program any aspects of my medical history and/or examination which may be appropriate or necessary for my evaluation and/or participation in the program.

I the undersigned do hereby authorize the Select Therapy and Fitness to furnish a report of the findings, evaluation and exercise report and all tests to my personal physician upon request. The statistical and scientific information obtained may be used as a means of acquiring research data.

The evaluation assessment has been explained to me by my instructors and any questions have been answered to my satisfaction. Potential risks and hazards to me in the program have also been explained to me by my instructors.

I wish to participate in the program and in consideration of the fitness and evaluation upon me I hereby release and hold harmless the staff of the Select Therapy and Fitness together with all of its agents, employees, officials from any or all liability, claims or suits, known or unknown arising in or out of any manner connected with my participation in the program at the Select Therapy and Fitness and the consequences thereof.

I have carefully read and understand the above information.

Signature _____ Witness _____ Date _____



Pre-authorized Debits/EFT

I authorize you and the financial institution listed below to initiate electronic debit entries, and if necessary credit entries and adjustments for any debit entries in error to my account. For my payment of my Select Therapy & Fitness membership dues,

I authorize payment by **Visa**
 MasterCard
 Discover

Account number _____

Expiration Date _____ VCode _____

Name _____

In the amount of \$ _____ to be withdrawn from my account on the 1st of each month.

Signed _____ Date _____

Name _____

I authorize payment by **Checking**
 Savings

Account number _____ Routing # _____

In the amount of \$ _____ to be withdrawn from my account on the 1st of each month.

Name _____

Financial Institution _____ Branch _____

Address _____

Signature _____ Date _____

Please attach a voided check or copy of the check

If you wish to put your membership on hold you must do so **before the 1st of the month.**

If you choose to put your membership on hold we will no longer keep this information. This is for the protection of your confidential information. When you re-start your membership you must fill out a new EFT form.

PERSONAL/MEDICAL HISTORY

Check each as it applies to you. Have you ever had:

T.B.	Yes___ No___ Unsure___	Asthma	Yes___ No___ Unsure___
Heart Attack	Yes___ No___ Unsure___	Allergy	Yes___ No___ Unsure___
Angina (Chest Pain)	Yes___ No___ Unsure___	Convulsions	Yes___ No___ Unsure___
EKG Abnormalities	Yes___ No___ Unsure___	Paralysis	Yes___ No___ Unsure___
Emphysema	Yes___ No___ Unsure___	Headaches	Yes___ No___ Unsure___
High Blood Pressure	Yes___ No___ Unsure___	Depression	Yes___ No___ Unsure___
Diabetes	Yes___ No___ Unsure___	Arm Pain	Yes___ No___ Unsure___
Stroke	Yes___ No___ Unsure___	Ulcers	Yes___ No___ Unsure___
Black Outs	Yes___ No___ Unsure___	Overweight	Yes___ No___ Unsure___
Gout	Yes___ No___ Unsure___	Hernia	Yes___ No___ Unsure___
Joint Problems	Yes___ No___ Unsure___	Back Pain	Yes___ No___ Unsure___
Glaucoma	Yes___ No___ Unsure___	Leg Cramps	Yes___ No___ Unsure___
Low Blood Pressure	Yes___ No___ Unsure___	Insomnia	Yes___ No___ Unsure___

Explain: _____

Do you smoke? Yes___ No___ How long have you smoked? _____

Approximate your daily usage: Cigarettes_____ Cigars_____ Pipes_____ Chewing Tobacco_____

If you do not smoke cigarettes now, did you ever? Yes___ No___

When did you quit? _____ How many per day did you smoke? _____ How many years? _____

Check each as it applies to a blood relative:

Heart Attack	Yes___ No___ Unsure___	Asthma	Yes___ No___ Unsure___
High Blood Pressure	Yes___ No___ Unsure___	T.B	Yes___ No___ Unsure___
Circulatory disorders	Yes___ No___ Unsure___	Diabetes	Yes___ No___ Unsure___
Thyroid disease	Yes___ No___ Unsure___	Stroke	Yes___ No___ Unsure___
Kidney disease	Yes___ No___ Unsure___	Allergies	Yes___ No___ Unsure___
High Cholesterol	Yes___ No___ Unsure___	Cancer	Yes___ No___ Unsure___
Rheumatic Fever	Yes___ No___ Unsure___	Ulcers	Yes___ No___ Unsure___
Heart disease	Yes___ No___ Unsure___	Lung disease	Yes___ No___ Unsure___
Glaucoma	Yes___ No___ Unsure___	Arthritis	Yes___ No___ Unsure___
Bleeding Tendency	Yes___ No___ Unsure___	Anemic	Yes___ No___ Unsure___
Stomach Problems	Yes___ No___ Unsure___	Mental disease	Yes___ No___ Unsure___

Check as applies to family history of cardiovascular disease (CVD):

___ No history of Cardiovascular disease ___ 1 relative under 55 with Cardiovascular disease

___ 1 relative over 55 with Cardiovascular disease ___ 2 relatives under 55 with Cardiovascular disease

___ 2 relatives over 55 with Cardiovascular disease ___ 3 or more relatives under 55 with Cardiovascular disease

Cardiac Risk Factor(s): _____

Have you ever taken medication for:

Heart Problem Yes___ No___ Unsure___ Diabetes Yes___ No___ Unsure___

List: _____ List: _____

High Blood Pressure Yes___ No___ Unsure___ Nervousness Yes___ No___ Unsure___

List: _____ List: _____

Other Medication Yes___ No___ Unsure___

List: _____

Exercise Habits in the Past Year:

- ___ Inactive, 0 days per week
- ___ Light, 1-2 days per week
- ___ Moderate, 3-4 days per week
- ___ Intense, 5 or more days per week.

Muscular/Orthopedic Section:

Have you had any recent muscular or joint problems?

Yes___ No___

List: _____

Select Therapy and Fitness Price List

Initial Membership Fee	\$70.00
Single Monthly Fee	\$37.00
Single Fee Pre-paid for 6 months	\$200.00
Couple Fee**	\$47.00
Couple Fee Pre-paid for 6 months	\$255.00
Family Fee**	\$57.00
Family Fee Pre-paid for 6 months	\$308.00
Senior Citizen Rate (60 or older)	\$26.00
Senior Couple Fee**	\$40.00
Initial Membership Fee – Student	\$45.00
Student Monthly Fee	\$34.00
6 Months Student	\$184.00
Junior Starter Membership (High School & younger) (6 week program)	\$73.00
Walk-in Fee	\$8.00

Corporate Rates:	
Single/Couple	\$25/\$35
Family \$5 each additional (after two) \$50 is the maximum charge allowed	
Corporate Membership Fee	\$35.00

Locker rental 12 months=\$27.00 6 months=\$17.00

****Couple Membership:**

A couple is a combination of two immediate family members living at the same address:

Husband/Wife Father/Son Mother/Daughter Brother/Sister, etc.

****Family Membership:**

A Family Membership pertains to 3 or more people in the same household and is handled in the same manner as a single or couple membership.

EFT/Credit Card Rates

Single monthly	\$34.00
Single pre paid 6 mo	\$189.00
Couple monthly	\$44.00
Couple pre paid 6 mo	\$248.00
Family	\$54.00
Family pre paid 6 mo	\$292.00
Senior single	\$23.00
Senior couple	\$37.00

Families/couples must be at the same address

Corporate EFT Rates

Single monthly	\$23.00
Couple monthly	\$33.00
Family 3	\$38.00
Family 4	\$43.00
Family 5	\$48.00

Families/couples must be at the same address

Personal Training from:



1425 S. Columbia Road
Grand Forks, ND 58201
(701) 746-1323

404 4th St N.
Devils Lake, ND 58301
(701) 662-3544

Personal training is just that, making your program as individual as you are, to reach your specific fitness goals. Training sessions may be used at any time to improve the quality of your workouts. Package sessions expire 6 months after the date of purchase. New members are encouraged to purchase 5 or 10 sessions when beginning their memberships to learn proper habits and increase their comfort zone.

You may utilize your personal training sessions with a variety of programs:

- Nutrition education
- Increasing flexibility
- Private aerobic sessions
- Improving cardiovascular workouts
- Free weights
- Program design

Single sessions: (Based on \$50/hr rates) 60 minutes - \$50
30 minutes - \$25

Package of 5: (Based on \$40/hr rates) 60 minutes - \$200
30 minutes - \$100

Package of 10: (Based on \$30/hr rates) 60 minutes - \$300
30 minutes - \$150

- 30 or 60 minute sessions
- More than 15 minutes late (full charge/no show)
- 24 hr cancellation required for no charge sessions
- Advance payment required
- NSF clients will be cash only
- Sessions non-refundable, transferable if used within 30 days
- No calls after 9 pm, except emergency calls to change appointments