

PETERSEN FAMILY WELLNESS CENTER

SHELBY COUNTY CHRIS A. MYRTUE MEMORIAL HOSPITAL

MEMBERSHIP AGREEMENT AND RELEASE OF LIABILITY

Date: _____ Card # _____ E-mail: _____

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

Home Address: _____

City/State _____ Zip: _____

Home Phone: _____ Cell Number: _____

Date of Birth: _____ Work Number: _____

Emergency Contact: _____ Phone # _____ Relationship _____

The undersigned (hereinafter referred to as "Member") desires to become a member of the Petersen Family Wellness Center, a health maintenance facility, owned and operated by Shelby County Chris A. Myrtue Memorial Hospital and to be entitled to all rights and privileges of such membership as described in this membership agreement.



I understand all **PPD memberships are FINAL** – no refunds will be issued. _____

(Member's Signature)

****TERM (Please Initial) _____** The initial term of the agreement shall be a period of twelve (12) months. Thereafter, this agreement will automatically renew for one (1) month periods unless cancelled in accordance with this agreement.

PAYMENT FOR MEMBERSHIP **This area to be filled in by PFWC Staff)**

Please Check Type of Membership:

12 mo. _____ 6 mo. _____ 3 mo. _____

Single: PPD _____ ABM _____

Couple: PPD _____ ABM _____

Family: PPD _____ ABM _____

Senior: PPD _____ ABM _____

Senior Couple: PPD _____ ABM _____

Youth: PPD _____ ABM _____

College Student: PPD _____ (1 mo. _____ 2 mo. _____ 3 mo. _____) ****Must provide a current college ID.**

Punch Card PPD _____ (Expires in 2 mo.)

MMC Retired PPD _____ ABM _____

MMC Ret. Couple PPD _____ ABM _____

Corporate Membership _____

Corporate Name _____

Corporate Percentage Rate _____

Fit For The Future Membership _____

Silver Sneakers Membership _____

Livewell Membership _____ (2 mo.)

Locker Rental _____

MEMBERSHIP DUES _____

In consideration for the privileges granted in this Agreement, Member agrees to pay Petersen Family Wellness Center the following:

The sum of \$ _____ upon the execution of this Agreement, as an initial fee, together with:

_____ A. Prepaid plan: The sum of \$ _____ upon the execution of this Agreement. Check _____ Credit Card _____

_____ B. Monthly Bank Draft/Credit Card (Please complete Bank Draft/Credit Card Authorization- EFT Form.)

(Please initial) _____ After the first twelve (12) months, this Agreement is terminable with thirty (30) days' written notice. Member understands and agrees that Member is responsible for payment to Petersen Family Wellness Center up through the end of the 30 day notice period. Payment for the balance owed through the end of the 30 day notice period is due five (5) days after the written notice is given by either Petersen Family Wellness Center or Member to the other.

The monthly membership fee is subject to change by Petersen Family Wellness Center upon 30 days written notice to Member. The new rate will be effective thirty (30) days after mailing or delivery of the notice of the rate increase to Member.

Any monthly payment that is not paid in full within 5 days after its due date shall be subject to a late charge of 10% of the monthly payment. The failure to demand or collect a late payment charge on any monthly payment shall not be deemed a waiver of the right to collect that charge on that payment or any other late monthly payment.

Except as specifically set forth in the General Conditions, failure to use Petersen Family Wellness facilities shall not relieve Member of the obligation to make the payments described above, nor entitle Member to a refund of all or any part of a payment.

Release of Liability

- I. In consideration of gaining membership or being allowed to participate in the activities and programs of the Petersen Family Wellness Center and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Shelby County Chris A. Myrtue Memorial Hospital, Shelby County Medical Associates, their Board of Director and Trustees, Petersen Family Wellness Center and it's officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Petersen Family Wellness Center or the use of any equipment at Petersen Family Wellness Center. **(Please initial)** _____
- II. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. **(Please initial)** _____
- III. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of Petersen Family Wellness Center or use the equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given a physician's permission to participate, or that I have decided to participate in activity and/ or use of equipment and machinery without the approval of my physician and do hereby assume all

responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

(Please initial) _____

Please read General Conditions of this Agreement before Signing.

The undersigned Member acknowledges that Member has read and will comply with the above contract terms.

Member's Signature _____ **PFWC by:** _____

Executed this _____ day of _____, 20_____, at Harlan, Iowa.

Parent's Signature if member is less than 18 years of age: _____

You, the member, may cancel this Agreement at any time prior to midnight of the third business day of the health maintenance facility after the date of this Agreement, excluding Sundays and holidays. To cancel this Agreement, mail or deliver signed and dated **Termination Request** which states that you, the member, are canceling this Agreement, or words of similar effect. Such notice shall be sent or obtained at Petersen Family Wellness Center, 1213 Chatburn Avenue, Harlan, Iowa 51537. Termination Request is available at the Wellness Center or on line at myrtuemedical.org under Wellness tab. All monies paid pursuant to this Agreement shall be refunded within ten (10) days of the receipt of the notice of cancellation, except that payment made for any health services received prior to such cancellation.

MEMBERS -- only 2 individuals over 21 yrs. may be on a membership. All members must live at the same address.

Add-on Members: **Please include first, middle initial & last name.

(1.) Name _____ (____) _____ **DOB** _____ **Card #** _____
(MI)
Relationship _____ **Address** _____ **Phone#** _____
Emergency Contact _____ **Phone#** _____

(2.) Name _____ (____) _____ **DOB** _____ **Card #** _____
(MI)
Relationship _____ **Address** _____ **Phone#** _____
Emergency Contact _____ **Phone#** _____

(3.) Name _____ (____) _____ **DOB** _____ **Card #** _____
(MI)
Relationship _____ **Address** _____ **Phone#** _____
Emergency Contact _____ **Phone#** _____

(4.) Name _____ (____) _____ **DOB** _____ **Card #** _____
(MI)
Relationship _____ **Address** _____ **Phone#** _____
Emergency Contact _____ **Phone#** _____

(5.) Name _____ (____) _____ **DOB** _____ **Card #** _____
(MI)
Relationship _____ **Address** _____ **Phone#** _____

Emergency Contact _____ Phone# _____

(6.) Name _____ (____) _____ **DOB** _____ **Card #** _____
(MI)

Relationship _____ Address _____ Phone# _____

Emergency Contact _____ Phone# _____

PETERSEN FAMILY WELLNESS CENTER – EFT FORM

Authorization For Electronic Payment of Membership Dues

I ask that Petersen Family Wellness Center start an electronic payment arrangement to pay monthly dues under the Membership Agreement with Petersen Family Wellness Center. I have read and agree to the following terms:

1. Petersen Family Wellness Center will draw checks or other instruments to its own order, or will direct the transfer of funds, to pay the monthly dues from the account I have designated below. This will be done each month under a regular schedule established by Petersen Family Wellness Center.
2. I may stop the arrangement by written notice to Petersen Family Wellness Center. The arrangement ends on the day Petersen Family Wellness Center receives notice.
3. Petersen Family Wellness Center may stop the arrangement by written notice to me. The arrangement ends on the day Petersen Family Wellness Center mails the notice.
4. If this arrangement ends, I will be responsible for those monthly dues covered by checks or other instruments, or fund transfers that are drawn or directed by Petersen Family Wellness Center prior to the day the arrangement ends. On and after that day, the remaining fees owed under the Membership Agreement must be paid in full.

CHECK

Name of

Depositor: _____ Routing#: _____

Account#: _____

Name & Address of Financial Organization: _____

(Must get VOIDED check & attach to membership)

CREDIT CARD

____ VISA ____ Master Card Account # _____ - _____ - _____ - _____

____ Discover Exp. Date: _____

THERE WILL BE A \$5 CHARGE ON ALL FAILED CREDIT CARD OR BANK ACCOUNT PAYMENTS.

I authorize you to pay and charge to my account any checks or instruments, or any fund transfers drawn or directed by Petersen Family Wellness Center to its own order. Until you receive my written cancellation of this authorization, you are fully protected when you honor any of those orders.

Your treatment of, and your rights regarding those orders, shall be the same as if I signed or instituted them. If any of those orders are not honored, for cause or not, you shall have no liability, even if membership is forfeited as a result.

Date: _____

Signature of depositor(s) as shown as
on Financial Organization records for
the account identified above.

✕ _____

✕ _____