HeartFit FOR LIFE

New Member Application

Tell us about yourself (please print all information):

Name (include nickname if appropriate) _____ Birthday (MM/DD/YY) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

Email Address _____

Emergency Contact _____ Phone _____

Since this is a Physician Referral program, tell us about your personal physician who referred you to our program:

Physician Name _____

Physician Address _____

Physician City _____ State _____ Zip _____

Physician Phone _____ Fax _____

HeartFit
FOR LIFE

Informed Consent for Exercise Therapy Agreement

I desire to engage voluntarily in the exercise cardiovascular wellness and rehabilitation program of HeartFit For Life in order to improve my cardiovascular function. My physician has recommended this program to me.

Before I enter this exercise program, I will have a clinical evaluation by my physician. This evaluation will include medical history and physical examination of but not limited to measurements of heart rate, blood pressure, and EKG at rest and with effort.

The purpose of this evaluation is to detect any condition which would indicate that I should not engage in this exercise program.

I understand that as a participant in a HeartFit For Life Initial Evaluation and Group Orientation, both I and other patients will discuss medical information in the presence of other patients, family members, and staff. If I have medical concerns of a private nature, I will ask to discuss them with HeartFit For Life staff privately.

By signing this form, I am agreeing to and authorizing the discussion of my personal medical information in a group setting during the Group Orientation. I also agree to respect the confidentiality of the other members of the group by not revealing medical or any other identifying information after the session is over.

The exercise program will follow a prescription based on my most recent treadmill test and will be carefully followed by the supervisor of the exercise program. The amount of exercise will be regulated on the basis of my tolerance.

The activities are designed to place a gradually increasing workload on the cardiovascular system and thereby to improve its function. The reaction of the cardiovascular system to such activities cannot be predicted with complete accuracy. There is the risk of certain changes occurring during or following the exercise. These changes include abnormalities of blood pressure or heart rate, or ineffective "heart function," and in rare instances, "heart attack" or "cardiac arrest."

Before starting the program, I will be instructed as to the signs and symptoms which I should report promptly to the supervisor of the exercises and which will alert me to modify my activities. I will also be observed by the supervisor of the exercises, who will be alert to changes which would suggest I modify my exercise. I agree to attend the complete exercise sessions as scheduled, including the warm up and cool down exercises.

For in-person classes, every effort will be made to avoid such events by the preliminary medical examination and by observation during the exercise. Emergency equipment and trained personnel are available to deal with and minimize the dangers of unpredictable events, should they occur. In the event of a serious emergency, 911 would be called. If I am taking an exercise class via Zoom; the nurses will be keeping in touch with me via phone or the chat feature to assess any symptoms I may have.

I understand that the HeartFit For Life program is never a substitute for the medical care rendered by my personal physician. I authorize HeartFit For Life to release to my personal physician information about my progress in the program. I also authorize HeartFit For Life to request information about my health from my personal physician, and/or any hospital where I have received care.

I agree to be responsible for the monthly payment of fees. I understand that I will be billed prior to each month's service and that payment is due on the 18th of that month. I understand that my payment of the monthly fees is not dependent upon reimbursement by my medical insurance policy but is solely my personal responsibility.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

Medical Release

I, _____

(print patient name) (print patient date of birth, MM/DD/YY)

hereby authorize any medical provider to release the following medical records, pertinent to my participation in the exercise wellness and rehabilitation program at HeartFit For Life, a program of the Cardiac Therapy Foundation.

The following medical records are pertinent and are to be released:

- Most Recent Hospital Discharge Summary, including
  - Report of CABG
  - Report of Coronary Angiography
  - Report of PTCA
  - Report of MI
- Report of Long Term Arrhythmic Monitoring
- Most Recent EKG
- History and Physical
- Most Recent Treadmill Report
- Pulmonary Function Test
- Lab Work (Lipid Panel, Chem. Panel)

X _____

Member/Patient Signature (for the Application and the Medical Release)

X _____

Date