Waiver and Assumption of Risk

Please consult with your physician before beginning any exercise program.

I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the "Programs"). I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue any class instructor, any Healthways participating location, any sponsoring organization, Healthways, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read and understand this waiver and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location or individual.

In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs.

- Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Diabetes
- Previous hip or spinal fracture (as an adult)
- Lung disease or shortness of breath after mild exertion, at rest, or in bed
- Open cuts on my feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- More than two falls in the past year (no matter what the reason)
- More than one year since I have engaged in regular physical activity

Print Member's Name	Member's Signature	Date
Emergency Contact Name	Contact Phone Number	

HEALTHWAYS

Incident Report

Please complete this form for all incidents involving members and report to your Program Advisor and Provider Services Liaison immediately. Please print all information.

Participating Location Representative Completing Form:	**Today's Date:**
Participating Location:	2013 - Olmsted Community Center 8170 Mapleway Dr. Olmsted Falls, OH 44138 Phone: (440) 427-1599 Fax: (440) 235-2265

Member Information:

Name:	
Address:	
Home Phone:	
Health Plan:	Healthways Member ID:

Description of Incident:

Date(s):
Time(s):
Witness:
Description of Incident:

HEALTHWAYS

HEALTHWAYS SilverSneakers® FITNESS

Promotion Code

Guest Pass Form

2013 - Olmsted Community Center

Welcome to SilverSneakers® Fitness program! If you are Medicare-eligible or a group retiree member, we invite you to enjoy any of the amenities offered here as part of SilverSneakers. Please fill out the information requested below along with the Waiver and Assumption of Risk and emergency contact information before beginning your physical activity. If you need assistance, feel free to ask the Program Advisor.

This Guest Pass is sponsored by SilverSneakers. By completing this form, I agree for my information to be shared with SilverSneakers. In addition, I agree that my information may be shared with Medicare Advantage health plans, and I may be contacted by health plans through direct mail at the address I submit below.

Health Plan / Insurance Company Name

Today's Date

Month / Day / Year

Last Name **First Name** **MI**

Address

City **State** **Zip Code**

Telephone **Gender** **Date of Birth**

Area Code - - M/F Month / Day / Year

Confidential

HEALTHWAYS

Exercise Your Opinion

Dear Member,

Our number one goal is to provide you a great fitness program. We want you to enjoy your visits and feel comfortable with the participating location staff, equipment and classes. Please share your comments and/or suggestions about how we can improve your experience.

I am a current member of:

- ☐ SilverSneakers
- ☐ Prime
- ☐ Forever Fit
- ☐ Healthways Reimbursement

I am:

- ☐ very satisfied
- ☐ somewhat satisfied
- ☐ neither satisfied nor dissatisfied
- ☐ somewhat dissatisfied
- ☐ very dissatisfied

Please tell us why: _____

_____

_____

How has this program improved your health: _____

_____

_____

Please print.

Member name: _____ Date: _____

Address: _____

City: _____ Phone: _____

E-mail address: _____

Participating location name: 2013 - Olmsted Community Center

Sponsoring health plan /organization: _____

By signing this sheet, I give permission for Healthways to use my comments and to be contacted directly regarding my testimonial via the contact information I have given.

_____

Signature

☐ Please check this box to receive updates and information from your fitness program via e-mail. Your e-mail address will not be shared with any third parties and you can opt out at any time.

Please fax completed form to **1-800-327-9151.**

Office use only Member name:

Date: HP: State:

HWAZ_1 2.11

Sign-In Sheet

HEALTHWAYS

2013 - Olmsted Community Center

If a member has not received his or her Healthways ID card, has forgotten it the day of the visit or there is a problem with the tracking device, you must manually record the member's visit on this form. For problems with the tracking device that will last more than one day contact Healthways. Another method of tracking participation will be used in this case. This document must be sent to Healthways by the 5th of the month with the month-end reporting to ensure proper activity reporting. **Information on this form is required for visits to be accepted.**

Today's Date M M / D D	Healthways ID Number	Last Name, First Name (Print Legibly)
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