



PAYMENT POLICY

Initial Program Payment:

Rehab 3 Center for Athletes requires payment for training programs on a monthly basis. The full program fee is due on the first day of the program. **Payments are final. No refunds will be issued.** Price will be dependent upon the program selected. Programs may not be changed once started. Our open enrollment policy allows participants to begin at any time during the month. Payment is good from the start date until the same calendar date the following month; which will then serve as your renewal date for subsequent months.

(Example: Start Date – April 13th, Renewal Date – May 13th)

Program Renewal:

Participants wishing to continue their sessions will be required to make a full program payment **prior** to their renewal date. Electronic reminders will be issued via email to assist timely payments. If you are not renewing, please alert us as soon as possible. Half month sessions are available at a discounted rate.

Make-Up Sessions:

Participants unable to attend a scheduled appointment are encouraged to call and reschedule another session. Participants must make up sessions **within** their paid month; extensions will not be granted. If Rehab 3 Center for Athletes is forced to close on a day you are scheduled, we will make every effort to ensure that appointment is rescheduled.

AUTHORIZATION

I accept financial responsibility for any and all charges received at Rehab 3 at Marsh Brook. I understand that this program requires pre-payment **before I begin or renew each session.**

Signature of Athlete (Parent/Legal Guardian
or Appropriate Consenting Party)

Date

GUARANTOR INFORMATION (for minors only)

Name:

Relationship:

Home Phone:

Address:

Work Phone:



PAST MEDICAL HISTORY:

1. Please check any condition you now have *or* have had in the past:

- Diabetes Stomach Problems Anxiety/Depression Heart Problems/Surgery
- Shortness of Breath Shoulder Problems Chest Discomfort Migraine/Recurrent Headaches
- Phlebitis or Emboli Broken Bones Ulcers Recurrent Cough
- Anemia Stroke Back Problems Trouble Sleeping
- Low Blood Pressure Neck Problems Hernia Peripheral Vascular Disease
- Pneumonia Epilepsy or Seizures Previous Surgery Foot Problems
- Ankle Swelling High Blood Pressure Cold Hands/Feet Fatigue/Lack of Energy
- Emphysema Arthritis Emotional Disorders Light Headedness/Fainting
- Joint Pain/Stiffness Rheumatic Fever Asthma Heart Murmur/Palpitations

Please explain any items checked below:

- 2. Please list any prescribed or over-the-counter medications you are currently taking:
- 3. Please list anything requiring hospitalization over the past two years:
- 4. Please list any known allergies:

WAIVER OF LIABILITY:

I understand that Rehab’s 3 Strength and Conditioning Program (“Program”) is designed for, and intended to be used by, individuals in good health and that participating in it may be harmful to individuals with certain medical conditions. Accordingly, I certify that I have discussed my participation in the Program with my physician, consulted with my physician about any health-related concerns I have regarding my participation in the Program, and have received medical clearance from my physician to participate in the Program.

I also understand that engaging in any exercise or sporting activity creates an unavoidable risk of injury or illness. Furthermore, I understand that the risk of injury or illness is increased if I fail to take reasonable steps to ensure my well-being while participating in the Program. Accordingly, I agree that I will take reasonable steps to ensure my well-being while participating in the Program including, but not limited to, engaging in proper warm-up and cool down activities; using the Program’s equipment properly; following the recommendations of the Program’s staff; and adhering to the Program’s rules.

I understand and agree that I am participating in the Program and using the facility and equipment at my own risk and agree to hold Strafford Health Alliance, d/b/a Rehab 3 at Marsh Brook, as well as its principals, employees, and agents, harmless and free from any liability relating to my participating in the Program and/or use of the facility or equipment. I further agree that I will indemnify and hold harmless Strafford Health Alliance, d/b/a Rehab 3 at Marsh Brook, as well as its principals, employees, and agents, from any claims asserted relating to my participation in the Program and/or use of the facility or equipment.

Signature of Participant

Witness to Signature of Participant

If the Participant is a minor, please complete the following:

I certify that: (1) I am the Participant’s parent or other legal guardian; (2) I have read the contents of this WAIVER; (3) the Participant has received medical clearance to participate in the Program; and (4) the Participant is mature enough to participate in the Program, understand the risks inherent in the Program’s activities, and take reasonable steps, including but not limited to those listed above, to ensure his/her well-being while participating in the Program. On behalf of the Participant and myself, I agree to hold Strafford Health Alliance, d/b/a Rehab 3 at Marsh Brook, as well as its principals, employees, and agents, harmless and free from any liability relating to the Participant’s participation in the Program and/or use of the facility or equipment. I further agree that I will indemnify and hold harmless Strafford Health Alliance, d/b/a Rehab 3 at Marsh Brook, as well as its principals, employees, and agents, from any claims asserted relating to the Participant’s participation in the Program and/or use of the facility or equipment.

Signature of Participant’s Parent/Legal Guardian

Witness to Signature of Participant’s Parent/Legal Guardian

Name of Participant’s Parent/Legal Guardian

Relationship to Participant



PARTICIPANT INFORMATION SHEET

Account Number:	Last Name:	First Name:	M.I.:	Date:
Parent's Name (if minor):				
Street Address:		P.O. Box:	Date of Birth: (mm/dd/yyyy):	
City:		State:	Zip:	
Home Telephone:	Cell # (parent's, if minor):		Work # (parent's, if minor):	
E-Mail Address (parent's, if minor):			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Sex: M ___ F ___
PROGRAM START DATE:		PROGRAM DAYS/ TIMES:		

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY CONTACT:		
Name:	Relationship:	Home Phone:
Address:		Work Phone:

PHOTO AUTHORIZATION

I give my permission to Rehab 3 to photograph my person for the express purpose of promoting all aspects of Rehab 3 and any other use of this form is prohibited. Original photograph(s) will be filed with strict confidence during its use in the same confidential manner as other personal records and I may inspect or obtain a copy of the protected information described by this authorization. I understand that Rehab 3 shall not condition training, payment, or enrollment in the Center for Athletes on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. I understand that this authorization may be revoked in writing and delivered to Rehab 3 at any time for further disclosure of the hard copy although revocation will not affect the disclosure of records whose release I have previously authorized. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal or state law protecting its confidentiality.

Signature of Athlete (Parent/Legal Guardian
or Appropriate Consenting Party)

Date

Signature of Witness/Rehab 3 Representative

Date