

Frazier Rehabilitation Institute



Community Fitness and Wellness
UofL Health – Frazier Rehabilitation Institute
250 East Liberty Street, Suite 100
Louisville, KY 40202
P: 502-582-7411 F: 502-587-4512
Email: CFW@UofLHealth.org



Community Fitness and Wellness Information Packet

Membership Fees

Our mission is to provide accessible activity-based interventions and exercise to improve health and quality of life for individuals within our community living with physically disabling conditions. Community Fitness and Wellness (CFW), located on the first floor of 250 East Liberty in Louisville, Kentucky, offers a variety of wheelchair accessible cardiovascular and strength-training equipment. Our highly-trained staff provide exercise modifications for each client to work toward health, wellness, and fitness goals.

Membership

❑ Basic Gym Membership – \$25/month

- Independent use of the accessible gym equipment Monday through Friday from 8 a.m.– 4:30 p.m.
- *Basic Membership fee is included with the purchase of any intervention scheduled weekly.*

Available Interventions

❑ Guided Exercise

- One-on-one guided exercises with a trained staff member.
 - 30-minute session: \$25
 - 60-minute session: \$45

❑ Functional Electrical Stimulation Cycle (FES)

- Upper extremity cycling
 - 60-minute session includes set-up time: \$45
- Lower extremity cycling
 - 60-minute session (single leg) includes set-up time: \$45
 - 90-minute session (both legs) includes set-up time: \$60

❑ NMES with Motor Task Training

- 60 minutes of task specific exercise utilizing neuromuscular electrical stimulation (NMES) to activate muscles which may aide a client's ability to perform a specific task. Additional 30 minute set up and taken down time. Includes one NMES unit and one trainer.
 - 90-minute session includes set-up time: \$65
- 45 minutes of task specific exercise utilizing neuromuscular electrical stimulation (NMES) to activate muscles which may aide a client's ability to perform a specific task. Additional 15 minute set up and taken down time. Includes one NMES unit and one trainer.
 - 60-minute session includes set-up time: \$50

Possible Financial Assistance

- Scholarships may be available.
- Worker's Compensation may support your CFW membership package.

For eligibility, please inquire with CFW team member.

Client Agreement

1. Payment for monthly membership and intervention fees is due, in advance of, the **first of each month**. Late payment will result in the client's removal from the schedule.
 - a. Advanced payment secures the time slot for staff and equipment usage for one month.
 - b. Known absences **MUST** be communicated prior to payment in order to be reflected on the invoice.
 - c. CFW will offer opportunities to reschedule missed sessions within the same month based upon our staffing and equipment availability. Failure to reschedule within the same month may result in lost sessions.
2. Clients and CFW staff should discuss goals of CFW participation and selection of activities. CFW staff may limit specific activities based upon client and staff safety, and they are trained in activity modification to promote client and trainer safety. If a particular activity is deemed unsafe by CFW staff, it will not be performed in CFW.
3. Client schedules will be maintained month-to-month; however CFW reserves the right work with the client to adjust scheduled times to meet the overall needs of the program and its clients.
4. The Medical Release Form will be updated and signed annually by the client's physician to acknowledge any changes in the physician's recommendations for client exercise.
5. CFW is a non-profit organization whose mission is to provide accessible healthy lifestyle and wellness resources to individual's living with physical impairments. We seek out grant opportunities and charitable donations to provide financial assistance to eligible clients based on need. However, the availability of financial assistance varies throughout the calendar year and is not guaranteed.
6. **CANCELLATION POLICY:**
 - To cancel a scheduled session, call the CFW office at **502-582-7411** with as much notice as possible, **at least by 2:00 p.m. on the day before the session**.
 - For cancellations provided **WITHOUT adequate notice** (after 2:00 p.m. on the day before the session), **CFW will retain the full cost of the session** that was charged to the client at the beginning of the month in which the cancellation occurred.
 - For cancellations provided **WITH notice** (before 2:00 p.m. on the day before the session), the cost of the canceled session will be credited on the next payment period, however, a **\$5.00 cancellation fee will be charged** unless the session is rescheduled within the same month. Because clients pay in advance, the cancellation fee will be included on the bill in the next payment period. This fee does not apply to schedule adjustments made prior to CFW scheduling and charging for the month (e.g., notice of change of schedule provided in a prior month).
 - **Chronic cancellations** may result in the reduction, or other adjustment, to the client's schedule.
 - For clients receiving CFW scholarships (financial assistance), **chronic failure to abide by this cancellation policy and chronic tardiness may result in the loss of scholarship.**

By initialing here, I signify that I read the above cancellation policy thoroughly and agree to abide by the requirements as stated.

Client Information/Application

To be Completed by the Client

First Name: _____ Last Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: () _____ Cell: () _____

Date of Birth: _____ E-Mail: _____

Emergency Name: _____ Phone: _____ Relationship _____

NATURE OF IMPAIRMENT

- | | |
|---|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Morbid obesity |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Cardio-pulmonary disease | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Post-polio syndrome |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Friedreich's ataxia | <input type="checkbox"/> Spinal muscular atrophy |
| <input type="checkbox"/> Guillian-Barre Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Visual impairment |

Date of Onset:

Level of Injury (SCI):

Other: _____

ADAPTIVE EQUIPMENT *currently used*

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> AFO/KAFO | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cane | _____ |
| <input type="checkbox"/> Crutch(es) | _____ |
| <input type="checkbox"/> Prosthesis | _____ |
| <input type="checkbox"/> Walker | _____ |
| <input type="checkbox"/> Wheelchair | _____ |

MEDICAL HISTORY

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Autonomic Dysreflexia | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> Seizures | _____ |

SURGICAL HISTORY

No Yes Allergies If yes, list: _____

No Yes Tobacco use If yes, how much/often: _____

No Yes Alcohol use If yes, how much/often: _____

No Yes Currently participating in outpatient therapy, rehabilitation or exercise program
If yes, where/when: _____

Release of Liability and Waiver

Community Fitness and Wellness Program

UofL Health – Louisville, d/b/a/ UofL Health – Frazier Rehabilitation Institute (“Frazier”) is a Kentucky nonprofit corporation. Frazier operates the Community Fitness and Wellness program (“Program”) to provide accessible health and wellness activities to people with physically disabling conditions. The Program includes a gym with a wide variety of health and wellness, exercise activities and equipment.

In consideration of the opportunity to use the Program’s facility and equipment,

I, _____, **agree to the following:**

Print Name of Participant

1. I understand and acknowledge that it is my responsibility to consult with a health care practitioner to determine my fitness to use the Program’s equipment, facility, and to participate in activities conducted at and by the Program.
2. I understand and acknowledge that engaging in health and wellness activities at the Program’s facility, including exercise, and using the Program’s equipment, involves risks, including risk of serious injury, permanent disability, and death.
3. By choosing to engage in health and wellness activities at the Program’s facility and using the Program’s equipment, I assume full responsibility for any injury, damage, or loss that may occur to me due to my use of the Program’s equipment or my participation in the Program’s activities.
4. **RELEASE OF LIABILITY:** I, on behalf of myself, my spouse, children, administrators, and heirs, hereby expressly and voluntarily release, and hold harmless UofL Health – Louisville, its directors, officers, employees, contractors, agents, and assigns, from liability for any and all damages, loss, or personal injury, including disability and death, that may occur to me due to my use of the Program’s facility, my participation in activities at the Program’s facility, or my use of the Program’s equipment, whether or not such damage, injury, disability, or death is caused by the negligent acts or omissions of UofL Health – Louisville, its directors, officers, agents, employees, instructors, and assigns.
5. **WAIVER:** I, on behalf of myself, my spouse, children, administrators, and heirs, hereby expressly and voluntarily waive my right to bring any and all claims, demands, or actions that I may have, presently or in the future, including claims of negligent acts or omissions, against UofL Health – Louisville, its directors, officers, employees, contractors, agents, and assigns, for their acts or omissions, or arising out of any damage, loss, or personal injury, including disability or death, related to my use of the Program’s facility, equipment, or my participation in the Program’s activities.

I hereby affirm that I have read this Release of Liability and Waiver Agreement, I understand its content and that it is a legal contract, and I execute this agreement as of the date written below.

Signature of Participant or Participant’s Legal Representative

Date

Billing Information

First Name: _____ Last Name: _____ Billing Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____ Email: _____

Method of Payment *Check One* Check Credit Card Debit Card EFT/Bank Draft

► **CREDIT/DEBIT CARD** Visa MasterCard Amex

Card Number: _____ Exp. Date: _____

Name (*as listed on card*): _____ CVV#: _____

► **BANK DRAFT**

I (we) hereby authorize UofL Health – Frazier Rehab Institute to initiate debit entries to my (our)

Checking Account **Savings Account**

at the depository financial institution named below and debit the same to such account(s).

Bank Name (Please Print): _____

Name(s) on Account: _____

Routing Number: _____ Account Number: _____

PLEASE ATTACH A VOIDED BLANK CHECK FOR ACCOUNT

Automatic Payment Authorization

This authority is to remain in full effect until 30 days after Frazier Rehab Institute has received written notification from me (or either of us). I understand that termination of this agreement can only occur if all transactions are resolved and my membership account is in good standing. I understand that fee(s) will be charged to (credit card) or debited from (debit card or bank draft) each month. I agree to pay a \$20.00 fee for failed transactions due to insufficient funds in my account.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

All revenue must be posted to the following: 70076056000301001

Payment Authorization Date: _____ Payment Amount: _____

Medical Release Form

To be Completed by a Physician

The Community Fitness and Wellness gym at UofL Health – Frazier Rehab Institute provides activity-based interventions for individuals living with physical impairments. The goal is to improve overall health, personal fitness, and quality of life through appropriate, but challenging interventions to improve flexibility, muscle strength, and cardiovascular/aerobic fitness. The program may include stretching, resistive training, aerobic conditioning, weight bearing, and electrical stimulation.

Please evaluate and indicate the level of participation and activities suitable.

Patient Name: _____ Date: _____

Patient Phone: () _____ Date of Birth: _____

Diagnosis: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Strength Training | <input type="checkbox"/> Lower Extremity FES Cycling | <input type="checkbox"/> NMES with Motor Task Training |
| <input type="checkbox"/> Cardiovascular Training | <input type="checkbox"/> Upper Extremity FES Cycling | |
| <input type="checkbox"/> Circuit Training | <input type="checkbox"/> Vibration Training | |
| <input type="checkbox"/> Other: _____ | | |

PHYSICIAN RECOMMENDATION

- No restrictions
- Approved with the following precautions:

- Not approved

Comments: _____

Physician's Signature: _____ Date: _____

Physician Phone: _____

Please return all forms to:

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