Chambers Health
The Wellness Center at Bayside

Fitness Center

Our multi-room fitness center helps residents live a healthier lifestyle. Physical activity is not just the best way to prevent illness, but it also expands quality of life and decreases depression.

Through our affordable membership plans, our members can join a variety of group fitness classes that cater to all types of fitness impact levels or enjoy the fitness equipment room filled with treadmills, recumbent bikes, an indoor heated pool as well as elliptical and strength machines.

Membership Packages

Chambers Health Community Center offers a variety of affordable membership packages to meet your needs whether it be for your entire family or a one-day pass. Pick a membership package and payment plan that best fits your lifestyle:

- **Individual** - For one person between 18-60 years old
- **Joint** – For two people (the second member must be spouse or dependent and least 13 years old)
- **Family** – For four people (members must be spouse and/or dependents at least 13 years old.)

In District Rates 77514, 77560, 77597, 77661

Membership*	Monthly**	Semi-Annual	Annual
Individual	$10	$60	$120
Joint	$20	$120	$240
Family	$40	$240	$480

Out of District Rates

Membership*	Monthly**	Semi-Annual	Annual
Individual	$20	$120	$240
Joint	$40	$240	$480
Family	$80	$480	$960

**Monthly payment memberships accept electronic transfers only. All payment plans accept, cash, credit card or checks.*

Note: Spouse and legal dependents are determined as described by the IRS. Standard activation fees apply for any additional dependents.

Chambers Health
The Wellness Center at Bayside

Fitness Center Membership Application

First Name _____ Last name _____

Address _____

City/State/Zip _____ Phone _____

Email _____

Date of Birth _____ Gender _____

Emergency Contact Name _____

Relationship to you _____ Phone _____

Physician name _____ Phone _____

Limitations/medications _____

_____

Membership

Type of membership: ☐ Individual ☐ Joint ☐ Family

Payment plan: ☐ Monthly ☐ Semi-Annual ☐ Annual

Additional member information for joint, family or senior joint plans only:

First & last name spouse/dependent: _____ DOB: _____

First & last name dependent 1: _____ DOB: _____

First & last name dependent 2: _____ DOB: _____

If you are registering more than two dependents in a family membership, please contact the community center.

Community Center Staff Use Only:

Membership Type: ☐ I ☐ J ☐ F Payment: ☐ M* ☐ Q ☐ S ☐ A

Expiration date of membership: _____

Member number: _____

Staff name: _____

Membership Fee: _____

Total due: _____

Payment Type: Cash ☐ Credit ☐ Check # _____

**EFT for monthly, must complete form*

Chambers Health
The Wellness Center at Bayside

Informed Consent for Exercise Participation **Member # _____**

I desire to engage voluntarily in Chambers Health Community Center exercise program in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardio respiratory system and to thereby attempt to improve its function. The reaction of the cardio respiratory system to such activities can't be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise. These changes might include abnormalities of blood pressure or heart rate.

I understand that the purpose of the exercise program is to develop and maintain cardio respiratory fitness, body composition, flexibility, and muscular strength and endurance. All exercise programs include warm-up, exercise at target heart rate, and cool-down. The programs may involve walking, jogging, swimming, or cycling (outdoor and stationary); participation in exercise fitness, rhythmic aerobic exercise, or choreographed fitness classes; or calisthenics or strength training. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by exercise target heart rate and perceived effort of exercise.

It has been recommended to me that I should consult with my medical provider before starting any exercise program to determine the safety of beginning an exercise program. In the event that a medical clearance must be obtained prior to my participation in the exercise program, I agree to consult with and obtain written permission from my medical provider prior to the commencement of any exercise program.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform the instructor of the symptoms.

Also, in consideration for being allowed to participate in Chambers Health Community Center exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless The Wellness Center at Bayside and its staff members conducting the exercise program from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during, or arising in any way from the exercise program.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

_____ _____

Printed Name Signature

_____

Date

Chambers Health
The Wellness Center at Bayside

Payment Methods

☐ **EFT** (Please attach a voided check)

ROUTING NUMBER	ACCOUNT NUMBER
FINANCIAL INSTITUTION NAME	TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS
I authorize Chambers Health Community Center to deduct membership dues from the account listed. I understand that cancellation must be made only through Chambers Health Fitness Center. I authorize a payment of _____ to be deducted on the ☐ 1st of each month ☐ 15th of each month beginning on _____.	
SIGNATURE	DATE

☐ **Credit Card** (Credit card information will be presented to Community Center membership staff at the initial transaction.)

I authorize Chambers Health Community Center to process payments for monthly membership dues from the credit card submitted. I understand that cancellation must be made only through Chambers Health Community Center. I authorize a charge to my credit card of _____ on the ☐ 1st of each month ☐ 15th of each month beginning on _____.	
SIGNATURE	DATE

Payment & Cancellation Policy

I agree to the selected payment plan and, as a member of Chambers Health Community Center, I accept the following resignation policy. If at any time I wish to discontinue the automatic payments I will notify Chambers Health Community Center in writing two weeks prior to the next payment date. If I miss the deadline, I accept the responsibility for membership dues processed.

_____ _____

Signature Effective Date

_____ _____

Printed Name Member Number