

# HEALTHCARE ON THE SQUARE

## Boydton Fitness Center

392 Washington Street, Boydton, VA 23917  
Phone: 434-738-6102

Fitness Director: Phil Fancher

### MEMBERSHIP INFORMATION

#### Hours of Operation:

Monday through Thursday 7:30 a.m. - 7:00 p.m. Friday: 7:30 a.m. – 6 p.m. Saturday: 8:00 a.m. – 12:00 p.m (noon)

#### Membership:

Boydton Fitness Center offers individual and family memberships. Monthly dues can be paid by cash, check or credit card, or on an annual basis.

Membership fees and dues are as follows:

Type	* Monthly Dues	Yearly Dues
Individual	\$ 35	\$ 385 (pay for 11 months and receive 12 <sup>th</sup> free!)
Family *	\$ 49	\$ 539 (pay for 11 months and receive 12 <sup>th</sup> free!)

\* Family membership is a husband, wife and one or more children **or** one parent and children 10 to 18 years of age (or up to age 23 with proof of college enrollment). Children must be accompanied by an adult at all time. \*See Membership Rules sheet. **NOTE:** *If you are a HealthCare on the Square patient you may qualify for a discount. Discount is calculated on family income. See Membership Services for details.*

#### Membership Includes:

- Annual fitness assessment
- One personally designated fitness program
- No limits on use of facilities during regular operating hours

#### Equipment:

- Treadmills
- Precor
- Recumbent Bikes
- Ergometer
- Legend Weight-Training
- Olympic Free Weights

#### MEMBERSHIP TERMS

- Memberships are non-transferable. Membership fees will not be pro-rated or refunded for early cancellation: refund or credit of membership fees may be granted for documented medical reasons only.
- All membership prices are subject to change
- Memberships cannot be postponed or delayed except in a medical emergency. Please contact us concerning your needs.

#### MEMBERSHIP HOLD POLICY

Qualification: Boydton Fitness Center (BFC) will only hold your membership if you are in good standing with all Enrollment Fees paid and you qualify as follows:

Medical Disability: You must provide BFC with verification from your physician stating your medical disability will prevent you from using the Facilities. The term for a medical hold is two (2) months and will resume automatically unless another form is given.

Dues During Hold: If BFC approves a membership hold your right to use BFC is also frozen or suspended. The term of the prepaid membership shall be extended for the same period of the hold. Membership will be reactivated at the end of your hold.

NOTICE: You must provide at least thirty (30) days notice for a hold request to allow BFC to process your request. If your request does not conform to the Membership Hold Policy, you will be notified that your request has been denied and your membership shall remain active unless cancelled.

No Other Holds Allowed: BFC will not allow any hold that does not comply with the foregoing policies.

#### Guest Policy:

Upon arrival, members must register their guest(s) at the service desk. All guests must sign the guest log and present a valid picture ID showing date of birth. Guests may visit a maximum of three (3) times with a guest pass or as a member guest. A \$5 fee is charged for the first 3 visits of a member guest. After the third visit, guests pay \$10 for a daily membership. Members may bring up to two (2) guests at one time unless prior arrangements have been made. Guests must be 16 or older and if under age 18 must be accompanied by a responsible adult. Members are responsible for the conduct of their guests. Guests not accompanied by a BFC member pay \$10 for a day membership.

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### Fitness Assessment

Membership at BFC includes an initial fitness assessment with one of our exercise physiologists. Follow-up assessments can be scheduled for three months, six months, nine months, or one year after joining BFC with a small fee required. The purpose of the fitness evaluation is to:

- Determine your current fitness level so you can establish reasonable short term and long term goals for fitness improvement.
- Provide a benchmark for determining your progress toward your fitness goals
- Our Fitness Staff will guide you through a series of tests to determine your muscular strength, endurance, flexibility, and aerobic capacity. Your blood pressure and heart rate will be taken at the beginning and monitored throughout the cardiovascular portion of the assessment. You will receive an analysis of your body composition – that is the lean tissue-to-fat ratio - so you can work to increase your muscle mass and reduce body fat as you pursue your fitness goals.

All fitness assessments include the following:

- Flexibility assessment
- Blood pressure analysis
- Height and weight measurements
- Submaximal cardiovascular test
- Body composition analysis
- Muscular strength endurance assessment

Our exercise staff will design and recommend an appropriate exercise program for you based on the results of your fitness assessment, medical history, and your personal fitness goals. You will be given a complete orientation, including details on the proper use of equipment and techniques for maximizing effectiveness of each workout.

#### How to prepare for your fitness assessment:

- Avoid exercising prior to your fitness assessment.
- Avoid tobacco and caffeine prior to your fitness assessment.
- Do not eat within a three-hour period before your assessment.
- Wear a T-shirt, shorts, or sweat pants and some type of athletic shoes. Please do not wear a leotard or tights; they may make it difficult to do body composition measurements.

### **CANCELLATIONS:**

In order to cancel or reschedule an appointment, you must contact your trainer at least 24 hours in advance of the scheduled appointment or you will be charged \$10 for that session.

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## HEALTHCARE ON THE SQUARE SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

### THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review the full Notice of Privacy Practices (NPP). If you have any questions about this notice, please contact the Privacy Officer at 434-738-6102.

#### WHO WILL FOLLOW THIS NOTICE:

- HealthCare On The Square Pharmacy
- HealthCare On The Square Dental Center
- HealthCare On The Square Medical Center
- HealthCare On The Square Fitness Center

This notice describes our privacy practices. All these entities, Sites, and locations follow the terms of the notice. In addition, these entities, sites, and locations may share health information with each other for the treatment, payment or health care operation purposes described in this notice.

### OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services that you receive from us. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or to others working in this office. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you: and
- Follow the terms of the notice that is currently in effect.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various ways in which we may use or disclose your information:

- Appointments/Reminders
- To allow oversight of the quality of the healthcare we provide
- To allow workers' compensation claims
- As required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or safety.

The full duties for all these uses are contained in the full NPP.

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## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request restrictions
- Right to a paper copy of this notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from the facilities Privacy Officer at 434-738-6102.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we may receive in the future. We will post a copy of the current notice in our facility. On the first page of the notice, in the top right hand corner, we will offer you a copy of the current notice in effect.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the secretary of the Department of Health and Human Services. To file a complaint with us, contact the facilities Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

## OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of care that we provide to you.

**HEALTHCARE ON THE SQUARE**

**Boydton Fitness Center**

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**Fitness Director:** Phil Fancher

I, \_\_\_\_\_, have received the Notice of Privacy  
(Member)

Practices from Boydton Fitness Center.

X \_\_\_\_\_ Date  
(Member/Guardian Signature)

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In lieu of member signature, I, \_\_\_\_\_, a staff member  
of Boydton Fitness Center, state that \_\_\_\_\_ has been given  
(Member Name)

our current Notice of Privacy Practices.

X \_\_\_\_\_ Date  
(Staff Member Signature)

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### AGREEMENT AND RELEASE OF LIABILITY

1. In consideration of gaining membership or being allowed to participate in the activities and programs of Boydton Fitness Center and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge I do hereby waive, release and forever discharge Boydton Fitness Center and its officers, agents, representatives, executors, and all others from any and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Boydton Fitness Center or the use of any equipment at Boydton Fitness Center. (Please initial\_\_\_\_\_)
2. I understand and am aware that strength, feasibility, and aerobic exercise, including the use of equipment is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to and expressly assume and accept any and all risks of injury or death.  
(Please initial\_\_\_\_\_)
3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of Boydton Fitness Center or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use or exercise equipment and machinery. I also acknowledge that it has been recommended that I a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given any physician's permission to participate, or that I have decided to participate in activity and/or use equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities. (Please initial\_\_\_\_\_)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**Fitness Director:**

Phil Fancher

### Physical Activity Readiness Questionnaire (PAR-Q) and You

Regular physical fitness is fun and healthy and increasing more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physical active. If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly. Check YES or NO

YES	NO	
		Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
		Do you feel pain in your chest when you're physically active?
		In the past month, have you have chest pain when you were not doing physical activity?
		Do you lose your balance because of dizziness or do you ever lose consciousness?
		Do you have a bone or joint problem that could be made worse by a change in physical activity?
		Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
		Do you know of <b>any other reason</b> why you should not do physical activity?

### YES to one or more questions

If  
You  
Answered

Talk to your doctor by phone or in person **BEFORE** you start becoming much more physically active or **BEFORE** you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk to your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

### NO to all questions

If you answered NO honestly to all questions, you can be reasonably sure that you can:

- Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

#### Delay becoming much more active:

- **If you are not feeling well because of a temporary illness such as a cold or fever. Wait until you feel better; or**
- **If you are or may be pregnant – talk to your doctor before you start becoming more active.**

**Please note:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name: \_\_\_\_\_

Signature \_\_\_\_\_

Signature of Parent or Guardian (if minor) \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

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### HEALTH HISTORY QUESTIONNAIRE

Last Name		First Name		Telephone (H)	Telephone (W)
Address:				State	Zip
Gender		Date of Birth	Age	Height	Weight
M      F					

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with the Boydton Fitness Center, please read the following questions carefully and answer honestly. All information will be kept confidential. Please check YES or NO.

YES	NO	
		Do you have a heart condition?
		Have you ever experienced a stroke?
		Do you have epilepsy?
		Are you pregnant?
		Do you have diabetes?
		Do you have emphysema?
		Do you feel pain in your chest when you engage in physical activity?
		Do you have chronic bronchitis?
		In the past month, have you had chest pain when you were not doing physical activity?
		Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?
		Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
		Has a physician ever told you or are you aware that you have high blood pressure?
		Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before the age of 55?
		Has a physician ever told you or are you aware that you have a high cholesterol level?
		Do you currently smoke?
		Are you male over 44 years of age?
		Are you female over 54 years of age?
		Are you currently exercising LESS than 1 hour per week? If you answered no, please list your activities.
		Are you currently taking medication? If yes, please list medication and its purpose:

What are your specific fitness goals at Boydton Fitness Center? (Indicate all that apply)

<input type="checkbox"/> Increase strength and endurance	<input type="checkbox"/> Improve Flexibility
<input type="checkbox"/> Improve cardiovascular fitness	<input type="checkbox"/> Improve muscle tone
<input type="checkbox"/> Reduce body fat	<input type="checkbox"/> Increase muscle mass
<input type="checkbox"/> Exercise Regularly	<input type="checkbox"/> Injury rehabilitation
<input type="checkbox"/> Sports conditioning	<input type="checkbox"/> Other:

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What are your specific health goals at Boydton Fitness Center? (Indicate all that apply)

<input type="checkbox"/>	Reduce stress	<input type="checkbox"/>	Improve nutritional habits
<input type="checkbox"/>	Control blood pressure	<input type="checkbox"/>	Control cholesterol
<input type="checkbox"/>	Stop Smoking	<input type="checkbox"/>	Achieve balance in life
<input type="checkbox"/>	Improve productivity	<input type="checkbox"/>	Reduce back pain
<input type="checkbox"/>	Feel better overall	<input type="checkbox"/>	Other:

What motivated you to join Boydton Fitness Center? (Indicate all that apply)

<input type="checkbox"/>	Convenience/location
<input type="checkbox"/>	Membership promotion
<input type="checkbox"/>	Peer support
<input type="checkbox"/>	Medical reasons
<input type="checkbox"/>	Tried Boydton Fitness Center as a guest
<input type="checkbox"/>	Other:

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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### Staff Use Only

Cleared to exercise: \_\_\_\_\_ Not cleared to exercise: \_\_\_\_\_

Reason: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Resting Heart Rate: \_\_\_\_\_ Resting Blood Pressure: \_\_\_\_\_