Community Fitness and Wellness Information Packet
Our mission is to provide accessible activity-based interventions and exercise to improve health and quality of life to individuals within our community living with physical impairments. Community Fitness and Wellness (CFW), located on the 9th floor of Frazier Rehab, offers a variety of wheelchair accessible cardiovascular and strength-training equipment. Our highly-trained staff of activity-based technicians (ABTs) 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.-5:30 p.m.
  - **Basic Membership fee is included with the purchase of any intervention scheduled weekly.**

**Available Interventions**

- **Guided Exercise – $35/session**
  - 60 minutes of one-on-one guided exercises with a trained staff member.
  - Sessions focus on client goals, including strength, flexibility, endurance, and mobility.

- **FES Cycle (arms/legs) – $40 per individual session**
  - Upper extremity cycling is a 30 minute cycling session with an additional 30 minute set up and take down time.
  - Lower Extremity cycling is a 60 minute cycling session with an additional 30 minute set up and take down time.

- **NMES with Motor Task Training – $60 per session**
  - 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 1 NMES unit and 1 trainer.

- **Locomotor Training (LT) – $150/session**
  - Locomotor training (LT) utilizes a specialized unweighting harness system positioned over an elevated treadmill to assist a client with achieving standing and stepping activities.
  - An LT session is scheduled for 90 minutes total, with 45 minutes spent on the treadmill.

**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. CANCELLATION POLICY:
   To cancel a scheduled session, call the CFW office at 502-582-7411 and leave a message by 2:00 p.m. the day before your scheduled appointment. This allows staff the time to offer the canceled session time to another client. Failure to cancel by 2:00 p.m. will jeopardize the client’s ability to reschedule in the same month or be reimbursed for the missed session. Untimely cancellations due to unforeseen circumstances may be considered exceptions, at the discretion of management. Sessions canceled by CFW will be rescheduled at the client’s convenience or the cost reimbursed.

3. Clients and Activity-Based Technicians (ABTs) should discuss goals of CFW participation and selection of activities. ABTs may limit specific activities based upon client and staff safety. ABTs are trained in activity modification to promote client and trainer safety. If a particular activity is deemed unsafe by ABT staff, it will not be performed in CFW.

4. 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.

5. 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.

6. 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.

Additional Questions
Miranda Garvin, Community Fitness & Wellness Program Director
miranda.garvin@uoflhealth.org
502-582-7455
Client Information/Application
To be Completed by the Client

First Name: __________________________ Last Name: __________________________ Date: __________

Address: ________________________________________________________________

City: __________________________ State: __________ Zip Code: __________

Home: (   ) __________________________ Work: (   ) __________________________ Cell: (   ) __________________________

Date of Birth: __________ E-Mail: __________________________

NATURE OF IMPAIRMENT

☐ amputation  ☐ morbid obesity
☐ arthritis  ☐ multiple sclerosis
☐ brain injury  ☐ muscular dystrophy
☐ cardio-pulmonary disease  ☐ Parkinson’s disease
☐ cerebral palsy  ☐ post-polio syndrome
☐ diabetes  ☐ spina bifida
☐ fibromyalgia  ☐ spinal cord injury
☐ Friedreich's ataxia  ☐ spinal muscular atrophy
☐ Guillain-Barre Syndrome  ☐ stroke
☐ lymphedema  ☐ visual impairment

Other: __________________________

Date of Onset: __________________________

Level of Injury (SCI): __________________________

ADAPTIVE EQUIPMENT currently used

☐ AFO/KAFO  ☐ cane
☐ crutch(es)  ☐ prosthesis
☐ walker  ☐ wheelchair
☐ other __________________________

MEDICAL HISTORY

☐ asthma  ☐ diabetes
☐ high blood pressure  ☐ other
☐ heart disease  ☐ seizures
☐ other __________________________

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  History of autonomic dysreflexia (AD)

☐ No  ☐ Yes  Medication list provided

☐ No  ☐ Yes  Currently participating in outpatient therapy, rehabilitation or exercise program
If yes, where/when: __________________________
UofL Health – Frazier Rehabilitation Institute is offering to the community an opportunity to utilize its physical fitness equipment and facility for the purpose of creating and maintaining a personal, physical fitness regimen. Prior to using the physical fitness equipment and facility, you must read, acknowledge and sign this consent and release of liability agreement.

I, ____________________________, the client or on behalf of the client, ("Client" is defined to include myself, children, spouse, parents, heirs, assigns, personal representatives, guardians and estate) consent and affirmatively elect to use the physical fitness equipment and facility offered by the Frazier Rehab Institute.

Prior to Client’s use of the physical fitness equipment and facility, a Frazier Rehab team member will conduct Client’s orientation to the physical fitness equipment and the facility. Client should consult with his or her physician prior to using the physical fitness equipment or facility and have the physician complete a Client Release to Participate form. The hours of operation for Client’s use of the physical fitness equipment and facility are Monday through Friday, 8 a.m. to 5:30 p.m., excluding holidays, subject to variation (change/expansion).

By signing this document, Client expressly represents that he or she is in good health and is capable of full participation in rigorous physical activity. Furthermore, Client agrees to assume all risk of personal injury while using the physical fitness equipment and facility. Client also agrees to release and hold harmless Frazier Rehab and any affiliate, associate, successors and assigns, as well as any trustees, officers, directors, employees and agents from any type of liability or loss arising from or in any way connected or associated with Client’s use of the physical fitness equipment and facility. Should Frazier Rehab be required to incur attorneys’ fees, expenses and/or costs to enforce this consent and release of liability agreement, Client agrees to indemnify and hold UofL Health – Frazier Rehab Institute harmless from all such fees, expenses and/or costs.

CLIENT HAS CAREFULLY READ THIS CONSENT AND RELEASE AND FULLY UNDERSTANDS ITS CONTENTS. CLIENT ACKNOWLEDGES THAT THIS IS A CONSENT AND RELEASE OF LIABILITY AGREEMENT, WHICH CREATES A CONTRACT BETWEEN CLIENT AND UOFL HEALTH – FRAZIER REHAB INSTITUTE.

Signature of Client:__________________________________________ Date:_________________

Legal Representative of Client’s Signature:_________________________ Date:_________________

Emergency Contact Information

Name:_________________________________________________________
Relationship:_________________________________________ Employer:_________________________________________________________
Phone: (H)_________________________(W)_________________________(C)_________________________
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 VOIED 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

Community Fitness and Wellness 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 functional electrical stimulation. Please evaluate and indicate the level of participation and activities suitable.

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

Patient Name: ___________________________ Date: ______________________

Patient Phone: ( ) ______________________ Date of Birth: __________________

Diagnosis: ______________________________

☐ Strength Training ☐ Weight Management/Nutrition Program ☐ Vibration Training
☐ Cardiovascular Training ☐ Lower Extremity FES*
☐ Circuit Training ☐ Upper Extremity FES*
☐ Other: ________________________________ ☐ Locomotor Training*

PHYSICIAN RECOMMENDATION

☐ No Restrictions

☐ Approved with Precautions

________________________________________________________________________

________________________________________________________________________

☐ Bone Density Evaluation Recommended

☐ Not Approved

Comments: __________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Physician’s Signature: ___________________________ Physician Phone: _______________________

Client’s Signature: ______________________________ Date: __________________________

Please return all forms to:
UofL Health – Frazier Rehab Institute – Community Fitness and Wellness
ATTENTION: KEVIN RICHARDSON
kevin.richardson@uoflhealth.org
220 Abraham Flexner Way, 9th Floor Gym • Louisville, KY 40202
Office: 502-582-7411 FAX: 502-582-7488