Abilities Movement:

Program Sign Up form

Section 1: Participant Information

First Name of Participants:

Last Name of Participants:

Parent/Guardian Name:

Phone #:

Email:

Section II: Program Interest

Please select the program you are interested

Personalized Fitness/Wellness/Healthy Living Classes

☐Personal Training

☐Personal Training for people with severe Medical needs

Sports Classes

☐Mighty Dunks Basketball Summer 2019 (July 11- Aug 15)

☐Power Wheelchair Soccer Spring 2019 Fall 2019

Please let Abilities Movement know if there are additional programs or resources you would like to see within you community. Thank you.

Please print and send to:
Email: Info@abilitiesmovement.org
Mail: Abilities Movement, Inc.
144 Fairport Village Landing, #332
Fairport, NY 14450

Abilities Movement PT
Registration Form:

Name: _____ Birthday:_____

Address:(Full mailing address)_____

Contacts- Home #:_____ Cell#:_____

Email: _____

Emergency Contact:_____ Number:_____

Program Registration: Please indicate what programs you would be registering for or interested in.

1. Programs Interested in:_____

Participant Survey: Please complete this form once a year. It will be used for developing the best program plan around each participant. Please complete all areas to the best of your abilities.

1. Documented Disability:_____
2. Areas of Interest/Dislikes:_____

_____

Communication: ❑ Verbal ❑Non Verbal, communication used:_____

3. Level of Mobility: Please check one ❑Ambulatory ❑Ambulatory / Assistive Devices

❑ Manual/Power Wheelchair(Self-Propelled) ❑ Wheelchair (Assistance Needed)

4. Level of Support Needed: please check one:

❑Independent ❑ Independent / Some Assistance ❑ 1 on 1 Support Needed

If 1 on 1 support needed, please describe level of support:_____

_____

____

5. Allergies/Dietary Restrictions:_____

Personal and Confidential
Please return to:
Abilities Movement
144 Fairport Village Landing, # 332
Fairport, NY 14450
(585) 690-4408

6. Other Special Considerations: _____

LIABILITY/WAIVER STATEMENT (All participants and legal guardians MUST complete and sign below):

I, _____, do hereby agree to hold harmless Abilities Movement and its officers, directors, employees, volunteers and others assisting in the programs administered by Abilities Movement. I fully agree that material aspects of the program have been explained to me and that I fully understand the risks and liabilities of the recreation programs and solely assume such risks. If parental or guardian confirmation is required by Abilities Movement to participate in any of our programs, I hereby agree to have such person or persons sign such release on my behalf.

I acknowledge that I am signing this waiver to be in effect for one year from the date of the signature. This waiver will cover all recreational programs accessed through AM.

I acknowledge that I am either covered directly or indirectly for hospitalization insurance in the state of New York and this coverage is primary for any injury sustained in this program.

I, _____, give permission to AM instructors to authorize

medical care for _____ in the event of an emergency.

I agree that the above information is accurate to the best of my knowledge. I agree to contact Abilities Movement, Inc. in the even any of this information changes.

_____ _____

Print Name Signature

_____ _____

Date Guardian Signature (If under 18)

Personal and Confidential
Please return to:
Abilities Movement
144 Fairport Village Landing, # 332
Fairport, NY 14450
(585) 690-4408

Abilities Movement, Inc.

SERVICE AGREEMENT

Abilities Movement, Inc Services agreement: dated _____ BETWEEN:

_____, Participant, Parent or Guardian on behalf of _____
(the "Client")

-AND-

Service Provider:
Abilities Movement, Inc (AM)

The following are the terms and conditions that both the service provider and the client will agree upon. The Service Agreement is subject to the items outlined in AM Terms and Conditions 10/18.

Services Provided

1. The Parent or Guardian of Client hereby agrees to hire AM to provide the Client with services (the "services") consisting of:

_____.

2. The Services will also include any other tasks which both AM and the Client may agree on. AM hereby agrees to provide such services to the Client.

Term of Agreement

3. The term of this Agreement (the "Term") will begin on the date of this Agreement and will remain in full effect until the completion of the Services, subject to earlier termination upon the request of the client. The Term of this Agreement may be extended by mutual written agreement of the Parties.

Dates of Service and Financial Responsibility

4. Services to be provided as follows:

_____

_____

Compensation

5. For the services rendered by AM as required by this Agreement, the Client will provide compensation (the "Compensation") to the Service Provider of **$60.00 per session.**

Self-Directed Information

6. If community classes are being submitted through a self-directed budget please provide the information below. You must state this when enrolling in AM classes.

Broker Name: _____ Financial Intermediary Name:

_____

Telephone: _____ Telephone: _____

Email: _____ Email:

_____

Address:

_____

City:_____ Zip:_____

Notice

7. All notices, requests, demands or other communications required or permitted by the terms of the Agreement will be given by US Mail and email to the client and Parent/ Guardian and the Service Provider, as follows:

_____
_____
_____
_____
_____

Abilities Movement
144 Fairport Village Landing, #332
Fairport, NY 14450
info@abilitiesmovement.org
(585) 690-4408

Modification of Agreement

8. Any amendment or modification of this Agreement or additional obligation assumed by either Party in connection with this Agreement will only be binding if evidenced in writing signed by each Party or an authorized representative of each Party.

Assignment

9. Abilities Movement will not voluntarily or by operation of law assign or transfer its obligations under this Agreement without the prior written consent of the Parent or Guardian of Client.

Agreement

I agree to the terms of this Service Agreement and attest that the above information is accurate to the best of my knowledge. I agree to contact Abilities Movement, Inc. in the even any of this information changes.

_____ _____

(Print Name) (Signature)

_____ _____

(Date) (Guardian Signature, If under 18)

_Abilities Movement, Inc._____

_____

(Service Provider Signature)

Abilities Movement, Inc.

Personal Training Terms and Conditions - 3/2019

Sessions

1. A single session lasts for 50 minutes. Sessions may be carried out in clients' homes, schools, or within the community (e.g. a trip to the park or community fitness center).
2. Double sessions are one hour and forty minutes in length.
3. Sessions may be used for assessment, observation, or fitness according to the client's wishes and the trainer's judgement of what would be beneficial.

Fees

4. Single sessions are charged at the rate outlined in the signed Service Agreement. Time spent planning and preparing before sessions and writing up notes after sessions is included in this price.
5. Fees are subject to annual increases to reflect the cost of living. Existing clients will be given 6 weeks notice of any changes in fees. Fee changes do not affect sessions which have already been invoiced.

Payment

6. Invoices will be provided to the bill-payer at the end of each calendar month
7. Payment for invoices is required within 30 days of the date of the invoice.
8. Payment is accepted by cash, check, credit card, or bank transfer. Bank transfers must use the invoice number as the reference for the payment.
9. If payment is to be made through a Self Directed Plan or other funding source (grant, scholarship, gift), the Client must inform Abilities Movement in writing with the complete contact information (agency, name, mailing address, email address, phone number) for billing, prior to the start of services.
10. The client and parent/guardian will be responsible to assure there are funds approved and available in the Self Directed Plan or other funding source budget for services. The client and parent/guardian will be required to pay for the service directly if payment from the funding source is refused for any reason or if payment is more than 8 weeks late.

Non-Payment

Failure to settle invoices within the timescales detailed above will result in the following process:

11. The bill-payer will be contacted with a friendly telephone call to remind him/her that payment is due. At this time payment is expected or a payment plan that is agreed upon by both the Client and the provider will be created, signed, and implemented
12. If payment or a n agreed-upon payment plan is not received within 7 days of the date of this phone call, a letter will be sent to the bill-payer reminding him/her that payment is

due, and specifying that a debt collector will be involved if payment is not received within 7 days of the date of the letter. Sessions will be stopped as of the date of this letter.

13. If payment is not received within 7 days of the date of the letter, then the non-payment will be referred to a debt collection service.
14. AM encourages all Clients to reach out to us to make a payment plan, if there is a challenge in paying for billed services.

Cancellation

14. Cancellation by the Trainer
    a. Service Provider will make all reasonable attempts to provide services at all scheduled times. If the Service Provider cancels an appointment, the session can be rescheduled at a date and time which is convenient for the client and the service provider. Parent or Guardian of Client will be notified as soon as possible of any need for Service Provider to cancel. Clients will not be billed for any sessions that are cancelled and not rescheduled by the provider.
15. Cancellation by the client before the day of the appointment
    a. Client and Parent/Guardian agree to give 24 hours-notice of the need to cancel a scheduled performance of services. Any cancellation should be made at least 24 hours in advance unless it is an emergency or a session will be charged to the client. It shall be the decision of AM (on a case-by-case basis) to charge for “no shows” (no formal advance notice), for Clients who constantly cancel without notice or who are repeatedly late for appointments.
    b. There shall be no charge for the first cancellation of a scheduled service, but subsequent cancellations shall cause Client to incur a fee equal to the amount of the missed session for each such occurrence, at the rate noted in the Service Agreement.
    c. There will be an allowance of one unpaid, cancelled, scheduled service per six months of each calendar year.
    d. Clients are responsible for all payments that are not covered by a funding source due to cancelation.
    e. Clients arriving late will receive the remaining scheduled session time, unless other arrangements have been previously made with the Service Provider. The session will be billed at the rate equal to the scheduled session.
    f. The following constitute failure to attend an appointment:
        i. The Service Provider arrives at the client's home for an appointment, but the client is not at home or will not participate.
        ii. The Service Provider attends a session in a community session and the client does not attend.

16. Holidays - Services will not be provided on federal holidays.

Incidents/Accidents

17. AM makes every effort to assure the safety of Clients. Parents/Guardians will be notified of any incidents or accidents which may occur and will be provided with a copy of the AM incident report completed relative to the situation.

Communication

18. Clients will update AM with any changes to mail, email, phone numbers, or financially responsible contact information.
19. The client and our parent/guardians will allow Abilities Movement to communicate with the individual's service coordinator and other team members that will be useful for providing our service. AM will have access to the client's information that including past goals, IFSP, and other information relevant to AM serving the client.

Modification of Terms of Service

20. Any amendment or modification of these Terms and Conditions will only be binding if evidenced in writing signed by each Party or an authorized representative of each Party.

I have read and agree to the terms presented in the Terms and Conditions document, dated 3/19:

_____
(Print Client Name)

_____ _____
(Date) (Client Signature)

_____
(Print Name of Parent or Guardian, if applicable)

_____
(Signature of Parent or Guardian, if applicable)

Abilities Movement Photo Release Form

AM engages in marketing efforts to promote community connections and awareness, in order to provide our services. Participants can help in these efforts by agreeing to the use of photos and videos for the purpose of sharing AM's services with the community.

I hereby grant the Abilities Movement, Inc. permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration. This Photo Release form will be in effect for one calendar year from the date of signature.

I understand and agree that all photos will become the property of Abilities Movement, Inc. and will not be returned.

I hereby irrevocably authorize Abilities Movement, Inc. to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge Abilities Movement, Inc. from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

☐ Photo release: I give AM permission to use any photos taken at events for advertising purposes.

☐ I DO NOT give AM permission to use any photos taken at events for advertising purposes.

_____	_____
Print Name	Signature
_____	_____
Date	Guardian Signature (If under 18)

Medical History Date: _____

Name: _____ Age: _____ Phone #: _____

1) Did you consult with a physician prior to beginning this program? Yes No

2) Do you take any medications? Yes No

If yes, please list: _____

3) Do you have any cardiac or respiratory diagnoses or concerns? Yes No

If yes, please list: _____

4) Are there any other medical diagnoses or concerns we should be aware of? Yes No

If yes, please list: _____

5) Do you frequently experience any of the following?

Chest Pain	Yes	No
Shortness of Breath	Yes	No
Extreme Fatigue	Yes	No
Fainting Spells	Yes	No
Swelling of Hands or Feet	Yes	No
Arm/Leg Pain	Yes	No
Back Pain	Yes	No
Knee/Ankle Pain	Yes	No

Please explain any yes answers: _____

_____

I understand that by engaging in a fitness program through Abilities Movement, Inc., I will be participating in health enhancing activities. I understand that there are risks involved with resistance training, cardiovascular and stretching activities. I agree that all instruction and use of all facilities shall be undertaken at my own risk and that I am physically able to undertake any and all instruction provided.

Participant:_____Date: _____