

# 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

- 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](mailto:Info@abilitiesmovement.org)  
Mail: Abilities Movement, Inc.  
144 Fairport Village Landing, #332  
Fairport, NY 14450

**Abilities Movement, Inc.**  
**Adapted Sports 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, Inc. (AM) 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

### Adapted Sports Program

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 3/19.**

#### **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.

#### **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 **the amount listed in the posted course description.**

#### **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](mailto: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. (AM)**

### **Adapted Sports Program - Terms and Conditions - 3/19**

#### **Sessions**

1. Sessions are billed individually and are calculated according to the number of classes per session
2. Sessions may be used for assessment, observation, or game play according to the coach's judgement of what would be beneficial.

#### **Fees**

4. Sessions are charged at the rate outlined in the signed Service Agreement.
5. Sessions are paid for in full and are not prorated for any missed classes that are due to a participant not attending. Service Provider will make all reasonable attempts to provide classes at all scheduled times. If the Service Provider cancels a class, the class can be rescheduled. Parent or Guardian of Client will be notified as soon as possible of any need for cancellation and the reschedule date. Clients will not be billed for any sessions that are cancelled and not rescheduled by the Coach.
6. Fees are subject to annual increases to reflect the cost of living. Existing clients will be given 4 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 start of each session.
7. Payment for invoices is required upon the start of the session in order for the participant to participate in the session.
8. Payment is accepted by cash, check, 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 AM 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 an 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. Participation in the class will be stopped as of the date of this letter and will not commence until receipt of payment. There will be no credit for classes missed due to non-payment.
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.

**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 3/2019:

\_\_\_\_\_  
(Print Client Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
( Client Signature)

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(Print Name of Parent or Guardian, if applicable)

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(Signature of Parent or Guardian, if applicable)

**Abilities Movement, Inc.**  
**Adapted Sports Photo Release Form**

Abilities Movement, Inc. (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)