

PERFORMANCE ATHLETICS

Adult Application Form and Billing Policy

Section A: Personal Information

Thank you for your interest in Performance Athletics. Your application will be evaluated and you will be contacted. All information will be kept confidential.

I. PERSONAL INFORMATION

Applicant's Name _____ Age _____ Sex _____ Marital Status _____
Dominant Side/Hand _____ Dominant Leg _____ Shooting Hand _____ Hitting Side _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Daytime Phone _____
Height _____ Weight _____ % Body Fat (if known) _____

II. HEALTH HISTORY

Personal Physician's Name _____
Physician's Address _____ Physician's Phone _____
Injury (if any) _____ Date Injured Occurred _____ Type _____
If injured, where and how did injury occur? _____

Physician's Diagnosis of Injury _____
Status of Injury (i.e., surgery/rehab) _____
If surgery, name of surgeon _____ Phone _____
If rehab, name of therapist _____ Phone _____
Where was rehab performed? _____
Any other injuries or non-sports related health problems? _____

III. TELL US A LITTLE ABOUT YOURSELF (PRINT IN YOUR OWN HANDWRITING, PLEASE)

Background (school, hobbies, career objectives): _____

Your expectations of Performance Athletics? _____

How did you hear about Performance Athletics? _____

FOR OFFICE USE ONLY

Date of Interview _____ Application Evaluator _____

Evaluation _____

Section B: Medical History

This section of the form should be completed by the applicant, and must be signed by both the applicant and the applicant's physician where indicated.

IV: MEDICAL HISTORY (TO BE COMPLETED BY APPLICANT)

Applicant's Name _____

Address _____ City _____ State ____ Zip _____

Date of Birth _____ Home Phone _____ Sports _____

Employer _____ Work Phone _____

Insurance Company _____ Policy No. _____ Family Physician _____

Please answer the following questions by circling the appropriate response. Use the next page of this form to explain any "Yes" answers to the following questions. Have or do you:

- | | | | |
|-----|--|-----|----|
| 1. | Have a medical problem or injury since your evaluation? | Yes | No |
| 2. | Ever not been allowed to participate in sports for a medical reason? | Yes | No |
| 3. | Ever been hospitalized? | Yes | No |
| 4. | Ever had surgery? | Yes | No |
| 5. | Have any missing organs (e.g., kidney, eye, testicle)? | Yes | No |
| 6. | Presently take any medication? | Yes | No |
| 7. | Have any allergies to medicine or insect bites? | Yes | No |
| 8. | Passed out during or after exercise? | Yes | No |
| 9. | Been dizzy during or after exercise? | Yes | No |
| 10. | Have chest pain during or after exercise? | Yes | No |
| 11. | Tire more quickly than your friends during exercise? | Yes | No |
| 12. | Have high blood pressure? | Yes | No |
| 13. | Been told you have a heart murmur? | Yes | No |
| 14. | Have racing of the heart or skipped heartbeats? | Yes | No |
| 15. | Have a family member that died of heart problems or sudden death before? | Yes | No |
| 16. | Have any skin problems? | Yes | No |
| 17. | Ever had a head or neck injury? | Yes | No |

- | | | | |
|-----|--|-------------------------|--------------------|
| 18. | Ever been knocked out or unconscious? | Yes | No |
| 19. | Ever had a seizure? | Yes | No |
| 20. | Ever had a stinger, burner, or pinched nerve? | Yes | No |
| 21. | Ever had heat cramps? | Yes | No |
| 22. | Ever been dizzy or passed out in the heat? | Yes | No |
| 23. | Have trouble with breathing or coughing during or after activity? | Yes | No |
| 24. | Use any special equipment (pads, braces, neck rolls, eye guards, kidney belt, etc.)? | Yes | No |
| 25. | Have any problems with vision? | Yes | No |
| 26. | Wear glasses or contacts? | Yes | No |
| 27. | Ever sprained/strained, dislocated, fractured, or had repeated swelling for any bones or joints? | Yes | No |
| 28. | Have any medical problems listed below? If Yes, please check all that apply. | Yes | No |
| | High Blood Pressure _____ | Rheumatic Fever _____ | Diabetes _____ |
| | Hepatitis _____ | Abnormal Bleeding _____ | Tuberculosis _____ |
| | Asthma _____ | Mononucleosis _____ | Other (List) _____ |

Please explain all YES answers from the questions above:

PART V: SIGNATURES

You must answer all questions below and sign your name in order to be examined:

- | | | | |
|----|---|-----|----|
| 1. | The above information is current and correct to the best of my knowledge. | Yes | No |
| 2. | If in the judgment of a representative of Performance Athletics, I need care or treatment as a result of an injury or sickness, I do hereby request, consent to and authorize such care as may be deemed necessary. | Yes | No |
| 3. | I recognize the evaluation to be done is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac test work will be performed. | Yes | No |

Applicant's Signature

Date

Section C: Waiver of Liability

This section of the form should be completed and signed by the applicant, or by the applicant's legal guardian if applicant is under 18 years of age, as well as by the applicant's physician where indicated below.

WAIVER

_____ (“**Applicant**”) acknowledges that he or she will be taking part in a program of exercise, rehabilitation and/or athletic training being offered to said Applicant through Performance Athletics. The undersigned acknowledges that the Applicant has undergone a complete medical examination exclusively in anticipation of this program by an independent physician who has determined that the Applicant is in appropriate medical condition to participate in a program of vigorous exercise and athletic training activities which may include, but are not limited to, jumping, running, weight lifting and conditioning and other exercises. It is acknowledged that medical clearance has been obtained specifically for such activities.

The Applicant desires to voluntarily utilize the services and, if applicable, facilities and equipment provided by Performance Athletics for the purpose of personal fitness, recreation, or fitness evaluation. As a consideration for the right and privilege of being permitted access to, and the use of, services or programs offered by Performance Athletics, and if applicable, facilities and equipment of its partners, the undersigned does hereby release Theodore Johnson and Performance Athletics, and its officers, agents and employees, from any and all liabilities of any kind whatsoever arising out of any physical or mental injury incurred or sustained by the undersigned while voluntarily preparing to use, using or cleaning up after using, any of the fitness programs, recreational or evaluation services and, as applicable, facilities and equipment provided by Performance Athletics; and furthermore, agrees to save and hold harmless Theodore Johnson and Performance Athletics and its officers, employees and assigns, arising out of the undersigned's use of the facilities and/or services.

Furthermore, the Applicant acknowledges that he or she may participate in activities involving physical exertion or exposure to heat or steam. The undersigned acknowledges that he or she has obtained independent medical approval to use the services or programs, and if applicable, facilities and equipment provided by Performance Athletics for the undersigned's participation in activities involving physical exertion and that the Applicant has made Performance Athletics aware of any limitations suggested by the Applicant's physicians.

The undersigned acknowledges and affirms that the Applicant has carefully read this release and has asked and obtained a satisfactory explanation of any part that the Applicant does not understand.

Applicant's Signature

Date

Signature of parent or legal guardian if applicant is under 18 years of age

Date

PHYSICIAN'S STATEMENT

I hereby certify that I examined and found the Applicant physically fit to attend and to participate in the physical fitness activities with Performance Athletics. I know of no impairments which would limit participation in program activities. (Please attach any comments).

Physician's Signature

Date

MEDICAL CLEARANCE (TO BE COMPLETED BY APPLICANT)

Section D: Medical Clearance

This section of the form should be completed by the Applicant, and must be signed by the Applicant where indicated.

Please answer the following questions by circling the appropriate response.

- | | | | |
|----|---|-----|----|
| 1. | Do you have a primary care physician?
If yes, name of provider: _____ | Yes | No |
| 2. | Have you had a physical from a health care provider within the past 12 months? | Yes | No |
| 3. | Have you had blood work from a health care provider within the past 12 months? | Yes | No |
| 4. | Please supply the name of the name of the provider that will provide medical clearance: Name of Provider: _____ | | |

Applicant's Signature

Date

Signature of parent or legal guardian if applicant is under 18 years of age

Date

Section E: Billing Policy

This Billing Policy and the Agreement for Services below (collectively, “**Agreement**”) represents the agreement under which Performance Athletics, Inc. (“**PAI**”) will provide services to the Applicant (“**You**” or “**Applicant**”). This Agreement will apply to any matter in which you retain PAI to provide services to you, unless otherwise agreed in a written document signed by PAI.

Services. PAI will provide the training, rehabilitation and/or exercise services described in the Agreement for Services and otherwise agreed in writing.

Hourly Charges. If the Agreement for Services provides that you will be billed by the hour, you will be charged at the hourly rate indicated therein for all time spent by PAI employees. Time is billed in minimum one-quarter hour (15 minute) increments. Hourly rates may be increased in PAI’s discretion, but not without providing you with prior notice of such increase.

Flat Fee Charges. If the Agreement for Services provides that you will be billed a flat fee charge, such flat fee will be non-refundable except in the event PAI is unable to perform its obligations pursuant to the Agreement for Services.

Termination by You. You may terminate this Agreement with PAI at any time by providing written notice to PAI. In such event, you agree to pay PAI all charges due pursuant to the Agreement for Services.

Termination by PAI. PAI may suspend its obligation to provide services to you at any time by providing you verbal or written notice of your failure to comply with

this Agreement, failure to pay invoices, failure to deposit any agreed retainer, failure to cooperate, or any activity that renders it unreasonably difficult for PAI to provide services to you.

Billing Disputes. Billing questions or disputes should be brought to the attention of PAI within fifteen (15) days after the invoice in dispute.

Collection Costs and Attorney’s Fees. If PAI files any lawsuit or otherwise incurs costs attempting to collect amounts overdue under this Agreement, you agree to pay PAI’s collection costs, court costs, and reasonable attorney’s fees.

Interest Charges. If invoices are not timely paid, PAI may apply an interest charge of 8% per year (or the maximum allowable rate, if lower), calculated monthly, to any invoice not paid within thirty (30) days.

Governing Law and Venue. This Agreement will be governed exclusively by Minnesota law. All disputes regarding this Agreement or PAI’s services must be brought only in Hennepin County, State of Minnesota, unless otherwise required by law.

Section F: Agreement for Services

PAI shall provide the following services to Applicant: _____

from _____ to _____.

Applicant shall pay PAI as follows:

\$ _____ flat fee \$ _____ per hour

PAI and the Applicant hereby agree to the above Agreement terms.

PERFORMANCE ATHLETICS, INC.

APPLICANT

By _____
Theodore Johnson
Its President

(Signature)