



PATIENT INFORMATION

NAME _____ LAST FIRST M

GENDER _____ AGE _____ DATE OF BIRTH _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PATIENT SSN _____ - _____ - _____ DRIVER'S LICENSE # _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

***IS IT OKAY TO LEAVE A VOICEMAIL CONCERNING PHYSICAL THERAPY OR OTHER SERVICES? YES NO

EMAIL (FOR US TO SEND HOME EXERCISES) _____

PREFERRED METHOD OF APPOINTMENT REMINDERS: VOICEMAIL TEXT EMAIL

EMPLOYER _____ STUDENT _____

OCCUPATION _____ WORK PHONE (_____) _____

EMERGENCY CONTACT NAME _____

EMERGENCY CONTACT # (_____) _____ RELATIONSHIP _____

***IF PATIENT IS NOT RESPONSIBLE FOR PAYMENT, PLEASE PROVIDE RESPONSIBLE PARTY INFO:

RESPONSIBLE PARTY- NAME _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____

EMPLOYER _____ PHONE (_____) _____

SIGNATURE REQUIRED TO SHARE INFORMATION WITH RESPONSIBLE PARTY

SIGNATURE OF CLIENT _____

INJURY INFORMATION

NOT APPLICABLE

DIRECT ACCESS or REFERRING PHYSICIAN _____

PRIMARY PHYSICIAN _____ TYPE OF INJURY _____

DATE OF INJURY _____ DATE OF SURGERY _____

REASON FOR REFERRAL: _____

INJURY HISTORY

DO YOU HAVE A CURRENT INJURY? YES NO

ARE YOU REFERRED BY A PHYSICIAN? YES NO IF YES, WHO? _____

IF YOU ARE CURRENTLY INJURED, PLEASE CHECK THOSE WHICH APPLY TO YOUR CURRENT CONDITION:

- ATHLETIC INJURY WORK-RELATED INJURY MOTOR VEHICLE ACCIDENT
- INJURY RELATED TO LIFTING INJURY RELATED TO FALLING OTHER _____

PLEASE LIST ANY PREVIOUS INJURIES: _____

DO YOU HAVE PAIN? YES NO

DO YOU NEED PHYSICAL THERAPY? YES NO

PLEASE INITIAL THE FOLLOWING

- ____ I HEREBY AUTHORIZE HEIGHTS PERFORMANCE TO PROVIDE TREATMENT.
- ____ I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY HEIGHTS PERFORMANCE. I UNDERSTAND THAT PAYMENTS ARE DUE AT THE TIME OF SERVICE.
- ____ I UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE FOR MORE 90 DAYS, I WILL BE SENT TO COLLECTIONS
- ____ I ALLOW THE RELEASE OF MY INFORMATION TO THE PREVIOUSLY STATED RESPONSIBLE PARTY (IF APPLICABLE)

SIGNATURE OF CLIENT/PARENT/GUARDIAN _____ DATE _____

Medical History Intake Form

Name:

Date of Birth:

Today's Date:

Please check any of the following conditions that you have **CURRENTLY** been diagnosed by your physician as having:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Encephalitis (Current diagnosis) | <input type="checkbox"/> Vertiginous/ Vestibular Syndromes |
| <input type="checkbox"/> Hypertensive Heart Disease | <input type="checkbox"/> Chronic Ischemic Heart Disease |
| <input type="checkbox"/> Acute Pulmonary Heart Disease | <input type="checkbox"/> Chronic Pulmonary Heart Disease |
| <input type="checkbox"/> Cardiac Dysrhythmias | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Venous Embolism/Thrombosis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease |
| <input type="checkbox"/> Chronic Ulcer of Skin | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Sciatica (Current diagnosis) |
| <input type="checkbox"/> Abnormal Posture | <input type="checkbox"/> LumboSacral, Neuritis or Radiculitis |
| <input type="checkbox"/> Anorexia/ Bulimia | <input type="checkbox"/> Digestive Problems |

Comments:

Please check any of the following conditions that you have **EVER** been diagnosed as having:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest pain, Angina, Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Bleeding/ Bruising | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Other Arthritic Conditions | <input type="checkbox"/> Emphysema/Bronchitis |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Chemical Dependency/Alcoholism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety/ Panic Attacks | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Light-Headedness |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Multiple Sclerosis/Parkinson's | <input type="checkbox"/> Cancer, |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Traumatic Brain Injury | if so what kind/type |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Extremities | |
| <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Menstrual Irregularities | |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Concussion: when? _____ how many? _____ | |
| <input type="checkbox"/> Gall Bladder issues | | |

Comments:

Please check any of the following conditions that an immediate family member (parent, brother, sister) has ever been treated for:

- | | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness |

Comments:

Please check any of the following symptoms you have recently experienced:

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Fever/Chills/ Night Sweats | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Accidents | <input type="checkbox"/> Do you cough or choke |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Burning | when you eat or drink? |

Comments:

Please list any surgeries or other conditions for which you have been hospitalized, including, the approximate date and reason for the surgery or hospitalization.

Date	Reason for surgery/hospitalization

Please list **ALL** Medications you are currently taking (including pills, injections, over-the-counter, vitamins, supplements etc.)

MEDICATION	DOSAGE	FREQUENCY	ADMINISTERED ROUTE

Comments:

Do you have allergies to Medications?

Do you have allergies to Other substances? (including but not limited to supplements, food, stings, insect bites, etc)

How many ounces of caffeinated beverages do you drink per day?

Do you use tobacco products? Yes No

If so, what kind and how much per day? Cigarettes, /day, Cigars, /day, Smokeless, /day

How many days per week do you drink alcohol?

If one beer or glass of wine equals one drink, how much do you drink at an average sitting?

WOMEN: Are you pregnant or think you might be pregnant? Yes No Due?

SPORT YOU PARTICIPATE IN:

LEVEL: (circle) PRO COLLEGE COMPETITIVE AMATEUR OTHER:

PERFORMANCE TRAINING GOALS:

CURRENT STRENGTH (CIRCLE) 1 2 3 4 5 6 7 8 9 10

CURRENT SPEED (CIRCLE) 1 2 3 4 5 6 7 8 9 10

CURRENT FLEXIBILITY (CIRCLE) 1 2 3 4 5 6 7 8 9 10

CURRENT NUTRITION (CIRCLE) 1 2 3 4 5 6 7 8 9 10

ARE YOU TRAINING FOR AN UPCOMING EVENT/SEASON? Yes No IF SO, WHEN? _____

HAVE YOU TRAINED IN THE PAST 12 WEEKS? Yes No

IF YES, WHAT TYPE OF PROGRAM? _____

Patient signature:

Date:

Relationship if other than patient / parent / guardian if minor:

Notice of Protected Health Information Practices (Privacy Policy)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Heights Physical Therapy LLC and Heights Performance LLC ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:
 - a. **Treatment.** We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.
 - b. **Payment.** We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.
 - c. **Health Care Operations.** We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.
2. **Uses and Disclosures With Patient Authorization.** Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.
3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.
4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:
 - a. **Uses and Disclosures Required by Law.** We will disclose your health information when required to do so by law.
 - b. **Public Health Activities.** We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.
 - c. **Abuse and Neglect.** We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.
 - d. **Regulatory Agencies.** We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.
 - e. **Judicial and Administrative Proceedings.** We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.
 - f. **Law Enforcement Purposes.** We may disclose your health information to law enforcement officials when required to do so by law.
 - g. **Coroners, Medical Examiners, Funeral Directors.** We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.
 - h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.
 - i. **Threats to Health and Safety.** We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
 - j. **Military/Veterans.** If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

- k. **Workers' Compensation.** We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
 - l. **Marketing.** We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.
 - m. **Appointment Reminders.** We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.
 - n. **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.
5. **Uses and Disclosures to Business Associates.** With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.
2. **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. **Right to Verbally Object.** You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. **Right to Seek an Amendment of Your Health Information.** You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.
5. **Right to an Accounting of Disclosure of Your Health information.** You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. **Right to Confidential Communications.** You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. **When Authorizations are Required.** An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.
8. **Right to Revoke Your Authorization.** You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
9. **Right to Opt-Out of Fundraising Communications.** We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at (970)-641-7369 or sending an email to kaylynn@heightsperformance.com with your instructions to opt out of fundraising communications.
10. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.
11. **Right to Receive Copy of this Notice.** You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at (970)-641-7389. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at kaylynn@heightsperformance.com. All complaints must be submitted to the Practice in writing at 718 N. Main St. Unit #18 Gunnison, CO 81230. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is 9-1-2013.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Heights Physical Therapy LLC and Heights Performance LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 718 N. Main St. Unit # 18 Gunnison, CO 81230, Attention: Compliance Officer
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I allow the following persons permission to access and speak with Heights regarding appointments, treatment and financial responsibilities:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature of Patient or Representative

Date

Patient's Name

Date of Birth

Social Security Number

Name of Personal Representative (if applicable)

Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied
_____ Not Applicable
_____ Other (explain) _____

Signature of Authorized Practice Representative

Date



Performance/Physical Therapy Attendance and 24-Hour Cancellation Policy

It is very important to your performance training/rehabilitation that you keep all of your appointments. We want to help you reach your full potential as quickly as possible. We understand that occasionally emergencies and unexpected situations arise and you may not be able to keep an appointment. Because of our busy schedule, we ask that you call **24-hours** in advance if you are unable to come. We will try to reschedule that appointment within the same week.

If you miss your appointment, cancel or change your appointment with less than 24-hours notice, you will be charged **\$25**. This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24-hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

We do our best to get your treatment started on time, so please try to arrive on time. If you are more than 10 to 15 minutes late, you may have to reschedule your appointment. If you have any concerns or questions, please feel free to discuss them with me.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Heights Performance/Physical Therapy as described above. You will be billed if an appointment is missed without adherence to the cancellation policy. Thank you for your understanding and cooperation. We look forward to working with you for the best training/recovery possible.

Trent Ezzell, PT, MPT

Patient name (please print) _____ Date _____

Patient or Legal Guardian (signature) _____



CONTRACT OF COMMITMENT

The purpose of participating in Heights Performance training is to improve your performance. Heights has assembled a staff that is highly educated, motivated, experienced, and dedicated to you, the client. The Heights Performance training program is specifically aimed at improving and developing training sessions to assist you in reaching your goals. Our programs are custom designed to complement the training we provide you, the participant, with the proper means to achieve your desired results. We are committed to put in maximum effort, honest communication, and professional instruction.

We are extremely proud of the participants we train and have very high expectations for you while you are here and after you complete the Heights Performance training program. As a participant, you are ultimately responsible for your own performance. Therefore, while you are participating in the Heights Performance training program, we as a staff will expect the following:

1. Maximum Effort
2. Honesty
3. Excellence
4. Enjoyment of the Process

Results are not guaranteed, they are earned, and to be sure you get the most out of your Heights Performance experience we ask that you sign this contract. It is confirming that you are committed to improving your performance, you are willing to give maximum effort, and that you will be honest with yourself as well as the Heights staff so we may strive together for excellence.

Client Name: _____

Client Signature (parent/guardian): _____

Date: _____



HEIGHTS PERFORMANCE LLC
TERMS AND CONDITIONS OF USE AND PARTICIPATION RELEASE OF LIABILITY

Participant Name: _____ (the "Participant")

1. Heights Performance, LLC ("Heights") agrees to provide facilities and instruction for sports specific performance, functional movement training, fitness, and other similar services (the "Programs") to the Participant, conditioned upon acceptance of the Terms and Conditions herein.
2. Participant acknowledges and agrees that Participant's participation in the Programs is for sports specific performance, functional movement training, fitness, and other similar services and not for treatment of a medical problem or disorder. Participant further acknowledges that any advice offered by a representative of Heights through the Programs does not constitute medical advice or treatment, nor is it a substitute for treatment or medical advice from a physical therapist, physician, or other medical professional.
3. Participant represents and attests that Participant is in good health and additionally that Participant is not currently under medical care for any condition that may prevent Participant from utilizing the Programs. It is the Participant's responsibility to consult with a physician prior to starting any of the Programs and to discontinue any Program if any medical condition does arise. Participant should follow any restrictions placed on Participant's activity by Participant's physician. Heights is not responsible for Participant's failure to consult a physician or follow physician's orders.
4. Participant is aware that exercise and the equipment and facilities in which the Programs are carried out involves risks and perils, including all risks of injury and death, and Participant assumes such risks. Participant expressly agrees and understands that all participation in the Programs shall be at Participant's own risk and that Heights, its affiliates, and each of their officers, directors, agents, servants and employees, shall not be liable for any claims, demands, injuries, damages, actions or causes of action arising from acts or omissions that may constitute negligence on the part of Heights, its affiliates or either of their officers, directors, agents, servants and employees. In consideration of Participant's participation in the Programs, Participant agrees to pay attorney fees and expenses incurred by any individual or entity whom Participant or Participant's representative or designee may make a claim against in an effort to challenge any terms of this release or in violation of the terms hereof, including but not limited to the release from liability and waiver.
5. Participant assumes all risk and responsibility for bring in any minor children or other guests onto the premises as well as all risks for any loss of or damage to property brought on to the premises. Participant shall indemnify and save harmless Heights and all other affected parties from any loss, damage or injury caused by such minor children and guests.
6. Participant agrees to abide by all rules and regulations of Heights. Heights may, in its absolute discretion, terminate Participant's participation in a Program for failure to abide by any rule or regulation.

Participant Signature: _____

Date: _____

(Parent or legal guardian must sign if participant is under the age of 18)