****

 **BRICKS FITNESS MEMBERSHIP AGREEMENT**

**Between Bricks Fitness and (please print name’s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Services Provided: Bricks Fitness obligations hereunder and the undersigned Member’s membership are conditioned upon (i) Member executing this Agreement and initializing as designated, (ii) Member executing a Release in the form provided by Bricks Fitness, and (iii) Member otherwise complying with this Agreement (including, without limitation, the Rules defined below) For purposes of the foregoing conditions, the term “member” shall include each individual (i.e., spouse and children) included in a membership. Conditioned on the foregoing, operating hours, as established from time to time, and (b) participate in any one or more group classes offered by Bricks Fitness from time to time. This is not an “open gym” format. By class or appointment-only training, unless otherwise noted. The facility is located at the address of 1447 Gentry St. KC MO 64116. Suite 300

Hours of operation as follows:

1. Operating Hours; varies; see front desk or Face Book @Bricksfitness

2. Weekly Classes; varies; see front desk or Face Book @Bricksfitness. Bricks Fitness may alter its location, operating hours, type and quantity of equipment, and type and frequency of its classes from time to time in its sole discretion. Fitness training is an evolving science. Thus, Bricks Fitness reserves the right to change its routines, classes and equipment to accommodate such evolution.

**Membership: Payment Member hereby subscribes for the following type of membership (Check all that apply):**

**Membership: All TAXES AND FEES INCLUDED. PLEASE NOTE CHILDREN UNDER 16 MUST SIGN UP IN PERSON ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN.**

1-Year Paid In Full Competitive Boxing Membership **= $1000.00**

**Start Date: Automatically begins when initial payment is made**

**End Date: 1-Year after initial payment is made** **This membership is limited to Competitive Boxing Classes only**

**Routing No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ACH Account No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_**

**Account Holder Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

BRICKS FITNESS

Manner of Payment:

Compliance with Rules:

Member shall abide by all membership and facility rules and regulations established by Bricks Fitness , which may be posted at the facility, provided in writing, or issued orally and which may be amended from time to time in the sole discretion of Bricks Fitness (collectively, “Rules”). I agree that improper or unauthorized use of the facility or violation of the Rules may result in member suspension or cancellation at Bricks Fitness ’s discretion. General: This Agreement, the Release and the Rules represent the complete understanding between Member and Bricks Fitness. No representations, written or oral, other than those contained in this contract are authorized or binding upon Bricks Fitness. Member understands that he/she is obligated to pay the membership fee regardless of whether Member uses the facility. Member agrees to promptly notify Bricks Fitness by mail, via email JOSH@BRICKSFITNESS.US, or in writing of any changes of address, phone, and/or bank account/credit card information. At the end of the term of this membership contract, it shall continue in effect on a month to month basis unless new rates have been installed or you provide notice of cancellation to terminate this contract. Cancellation Rights: You may cancel this contract for one or more of the following reasons by delivering written notice of cancellation to: Solid Bricks Fitness, Attn: Manager, 1447 Gentry Street KC MO 64116 Relocation: If member moves his/her residence more than twenty-five (25) miles from the Facility, Member may cancel his/her membership subject to a $50 service charge. 2. Death; Disability: In the event that a Member dies or becomes disabled, then upon notice to Bricks Fitness the Agreement shall terminate as of the date Member could no longer use the membership. If prepaid, the Member shall be entitled to a pro rata reimbursement for the period after termination. For purposes of this provision, “disability” means a condition which precludes the member from physically using the facilities as verified by a physician. YOU, THE BUYER, MAY CANCEL THIS AGREEMENT AT ANY TIME PRIOR TO MIDNIGHT OF THE FIFTH (5TH) BUSINESS DAY OF THE HEALTH STUDIO AFTER THE DATE OF THIS AGREEMENT, EXCLUDING SUNDAYS AND HOLIDAYS. TO CANCEL THIS AGREEMENT, VIA EMAIL JOSH@BRICKSFITNESS.US, MAIL OR DELIVER A SIGNED AND DATED NOTICE, WHICH STATES THAT YOU, THE BUYER, ARE CANCELING THIS AGREEMENT, OR WORDS OF SIMILAR EFFECT. SUCH NOTICE SHALL BE SENT TO: BRICKS FITNESS, ATTN: Manager, 1447 Gentry Street KC MO 64116. IF THE TOTAL FEES DUE ARE PAID IN FULL IN GOOD STANDING, THEN TERMINATION RIGHT SHALL BE GRANTED 30 DAYS AFTER IT HAS BEEN EXECUTED BY THE MEMBER.

I certify that I have read and understand all of the terms of this agreement and agree to abide by all of the terms of this Agreement. Member (please sign):

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH HISTORY INFORMATION:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_ GENDER: MALE/FEMALE\_\_\_\_\_\_\_\_\_\_

PHONE#: (HOME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MOBILE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WORK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions: Diagnosed hypercholesterolemia (total cholesterol greater than 200mg/dl or HDL less than 35 mg/dl) YES OR NO

TOTAL CHOLESTEROL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosed hypertension (blood pressure greater than or equal to 140/90 mg/dl) YES OR NO

Any smoking habits? YES OR NO

Any past history? YES OR NO

Diabetes? (adult or juvenile) YES OR NO

Any family history of heart disease prior to the age of 55? YES OR NO

Any drinking habits? (alcohol)? YES OR NO

How much? \_\_\_\_\_\_\_\_\_\_\_\_

WOMEN: Are you 55 years of age or older? YES OR NO

MEN: Are you 45 years of age or older? YES OR NO

List any medications or allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any and all surgeries, illnesses or injuries (ortho) that you have had or have:

When was your last physical check up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions (please specify)

Any heart/vascular problems:

Any metabolic disease: \_\_\_\_\_

Heart disease, heart attack, angina \_\_\_\_\_\_

Kidney disease \_\_\_\_\_

Coronary angioplasty/cardiac surgery \_\_\_\_\_\_

Thyroid disorders \_\_\_\_\_

Rapid heartbeats/palpitations \_\_\_\_\_\_ liver disorders \_\_\_\_\_

Heart murmurs or unusual cardiac findings \_\_\_\_\_

Peripheral vascular disease Any respiratory disease: \_\_\_\_\_

Stroke \_\_\_\_\_

Asthma \_\_\_\_\_

Other \_\_\_\_\_

Chronic bronchitis \_\_\_\_\_

Emphysema \_\_\_\_\_

Other Any shortness of breath \_\_\_\_\_\_\_

Unusual fatigue \_\_\_\_\_\_\_

Ankle swelling \_\_\_\_\_\_\_

Chest discomfort at rest or during exertion \_\_\_\_\_\_

Faint or dizziness \_\_\_\_\_\_\_

I verify that all information notes above are accurate. I understand that it is my responsibility to update the staff of Solid Bricks Fitness of any changes in my medical status and it is also my responsibility to obtain medical clearance from my physician if needed to participate in my personal training program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT IN CASE OF AN ACCIDENT: NAME OF CONTACT PERSON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE# (HOME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WORK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO CLIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF CONTACT PERSON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE# (HOME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WORK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO CLIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU ALLERGIC TO ANYTHING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS AT THE PRESENT TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHOICE OF HOSPITAL YOU WOULD LIKE TO BE TAKEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT TYPE OF INSURANCE DO YOU HAVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_