Cleveland Physical Therapy Associates & Prescription Fitness

PRESCRIPTION FITNESS AGREEMENT, DISCLOSURE AND AUTHORIZATION

Today's Date: _____

Name: _____

Address: _____

_____ Phone: _____

Birth Date: _____ SS#: _____

Type of Membership: _____ ***Primary $40 Month*** _____ ***Sponsored $25 Month***

I agree to pay to Cleveland Physical Therapy Associates, Inc. for my membership fee of $40.00 a month payable upon the execution of this agreement, and at the 1st of each month thereafter.

My immediate family member, _____ will also be joining Prescription Fitness at a sponsored rate of $25.00 a month.

If I or my family member chose to cancel the membership with Prescription Fitness, I agree to provide 30 days written notice prior the cancellation taking effect.

_____ _____

Signature of Member Signature of Sponsored Member (if applicable)

_____

Signature of Parent/Guardian (for minor under age 18)

_____

Authorized Representative Date