

**REGIONAL THERAPY CENTER
OF
SARATOGA HOSPITAL**

**After Therapy Club
Participant Agreement**

I, _____ of _____
(Print Name) (Address)

will be participating in the After Therapy Club.

Method of Payment and Refunds:

I agree to pay \$_____ per visit (purchased in increments of 5 coupons) and I understand that that there are no refunds for unused or lost visit coupons.

Release:

1. I expressly agree that all exercises and use of all equipment and facilities of the Regional Therapy Center of Saratoga Hospital shall be undertaken by myself at my sole risk and that Saratoga Hospital and its employees or agents shall not be liable for any claims, demands, injuries, damages, actions or causes of action what-so-ever to myself or my property arising out of or connected with the uses of services or facilities of the Regional Therapy Center After Therapy Club.
2. I hereby expressly forever release and discharge Saratoga Hospital from all such demands, claims, injuries, damages, actions, and causes of action.
3. I understand that it may be necessary for the Regional Therapy Center to treat patients during the hours open for the After Therapy Club program. I understand, and agree, that patient treatment and services will have priority in the utilization of equipment and therapy staff time.
4. I certify that, to the best of my knowledge, I am in good health and there is nothing preventing me from engaging in an exercise program.
5. I agree to inform the Regional Therapy Center immediately of any change in my physical condition which might adversely affect my ability to safely participate in the program.
6. I agree to abide by Regional Therapy Center and Hospital rules and regulations governing participation in the program.

Signature of Participant Date: _____

Signature of Witness Date: _____