Yoga for Optimal Health
832 Germantown Pike, Suite 3
Plymouth Meeting, Pennsylvania 19462
610-239-8626 Fax 610-239-0288
www.cheikin.com drc@c4oh.org

Individual Class/Workshop Participation Agreement & Registration

12/29/08-35 f_yre_wk.wpf

Name: _____ Date of Birth: _____ Age: _____

☐ No change since last registration (please sign consent below and make sure email is correct)

Class or Workshop this registration applies to: _____

Street Address: _____ Apt: _____

City, State, Zip: _____

email (for notifications): _____ Do you wish to be on our mailing list? Yes No

Home Phone: _____ Work Phone: _____ Cell: _____

Contact Person for Emergencies: _____ Phone: _____

Primary Physician: _____ Primary Hospital: _____

How did you learn about this class/workshop? _____

Prior sport, yoga, dance experience (when, what type)? _____

Current sports/activities? _____

Medical Condition(s): _____

Your goals: _____

RELEASE FOR PARTICIPATION IN CLASS/WORKSHOP

I request to participate in the Class/Workshop named above. I agree to abide by all policies regarding safety and registration (see registration information).

I have agreed to discuss the risks and benefits of such participation with my doctor(s) and other health care practitioner(s), especially if I have any questions or concerns. I understand that I am required to continue my usual medical care. I understand that this Class/Workshop will not replace, substitute for, review or recommend routine medical care. **I understand that if I have or develop any new medical condition, especially, but not limited to the following conditions, I am strongly advised to schedule a consultation with Dr. Cheikin prior to beginning/continuing class: glaucoma, retinal detachment, aneurysm, angina, heart attack, stroke, uncontrolled high blood pressure, rheumatoid arthritis, disc herniation.**

I understand that if I am pregnant or planning to get pregnant that I am strongly advised to discuss the risks and benefits of such participation with my doctor(s), midwife and other health care practitioner(s) before beginning.

I understand that there may be recording (photos, video, audio) of this class & grant permission to Dr. Cheikin and his staff to utilize same for marketing or research purposes, which may depict me, at their discretion, without compensation paid to me.

NOTICE: Most (if not all) insurance companies (such as Medicare, PPO's, HMO's, etc.) will not cover the services that this Class/Workshop provides. As such, I understand and agree to be personally and fully responsible for payment.

I understand that fees are non-refundable and apply only for the periods specified at the time of registration.

In consideration of my being able to participate in this program, I agree to release all liability and to indemnify The Center for Optimal Health LLC, Wyndmoor Rehabilitation Associates, PC, Dr. Cheikin, and their respective affiliated companies, including the owners and operators of the facility in which these services will be provided, their officers, directors, shareholders, agents including independent contractors, employees, representatives and their successors and assigns, from and against all claims, actions, judgment, cost, expenses and demands with representatives and their successors and assigns, from and against all claims, actions, judgments, cost, expenses, and demand with respect to injury, loss, death or damage to my person or property in connection with my taking part in the above stated program. It is understood and agreed that this release is to be binding on myself, my heirs, executor, administrators and assigns.

I certify that I have read the above and understood it. Intending to be legally bound hereby, I make this agreement.

_____

Signature ((Parent or Guardian) Date

Total Classes: _____ Total Fee*: _____** **Add 3% if using credit/debit card

* If discount applied, type of discount: ☐ Senior ☐ Full-time student ☐ Hardship (speak with Dr. Cheikin)

Card Start Date: (Monday): _____ Name of Partner if two Cards: _____

PAID BY ☐ CHECK #_____ Please make check to: "Wyndmoor Rehab Associates" ($25 fee for bounced check)

☐ VISA** CARD#: _____ SIGNATURE: _____

☐ MASTERCARD** VCODE (3 DIGITS ON BACK): _____ EXPIRES: _____ / _____

Mail to: YOGA REGISTRATION; Center for Optimal Health; 832 Germantown Pike, Suite 3, Plymouth Meeting PA 19462. Call 610-239-8626 or email us at drc@c4oh.org with any questions.

OFFICE USE ONLY: Student #: _____ MSR#: _____ Start Date: _____ End Date: _____ Total: _____