



**Yoga for Optimal Health**  
 832 Germantown Pike, Suite 3  
 Plymouth Meeting, Pennsylvania 19462  
 610-239-9901 <http://www.cohlife.org/yoga>

**Individual Class/Workshop Participation Agreement & Registration**

12/13/2022 yoga\_registration\_form\_2022\_12\_13.docx

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: \_\_\_\_\_ 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): \_\_\_\_\_

PAID BY  CHECK # \_\_\_\_\_ Please make check to: "Wyndmoor Rehab Associates" (\$35 fee for NSF)

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 610-239-9901 or email us at staff@cohlife.org with any questions.**

OFFICE USE ONLY: Student #: \_\_\_\_\_ MSR#: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Total: \_\_\_\_\_