



Member Agreement

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____

Emergency Contact: _____ Phone: _____

DOB: _____ Physician(s): _____ Phone: _____

Initiation Fee: _____ Dues _____ MyTrak® \$_____ Monthly Dues _____ Dues _____ MyTrak® \$_____

Amount Paid Today: \$_____ Paid with: _____ Cash _____ Credit _____ Check _____ EFT

Hourglass Weight Loss & Fitness – Chatham No. 1, LLC I/a Hourglass Weight Loss & Fitness (hereinafter "Hourglass") welcomes you to our facility and program.

Membership Options:

_____ Member agrees to maintain membership for a minimum of twelve (12) months on draft. Automatic payment will continue after the 12-month period unless or until member cancels. Cancellation requires a 30-day notice. Monthly Fee: \$_____.

_____ Monthly Maintenance Fee. Member must pay dues within ten(10) days of each due date or membership will be cancelled. Reinstatement Fee: \$_____ Monthly Fee: \$_____

_____ Family Membership Monthly Fee: \$_____ This includes the following Members: _____

_____ Prepayment of annual Membership. Annually: \$_____

Cancellation: A 30-day written notice is required if member chooses to cancel during the first year with a cancellation penalty payment equal to One Hundred and Fifty dollars (\$150) tendered at the time notice of cancellation is tendered. To be effective a cancellation letter and cancellation fee must be received at 111 Jazie Drive #F, Savannah, GA 31410 by midnight not less than Thirty (30) days prior to the anticipated last monthly pre-authorized payment in order to be effective. After the expiration of the contract term, no cancellation fee shall be charged; however timely notice of cancellation is required. Members are guaranteed that monthly dues will not increase as long as membership is paid timely as agreed.

I understand that I cannot transfer my membership to another person and that I have FIVE business days to cancel this contract by mailing or delivering a letter to Hourglass, 111 Jazie Drive #F, Savannah, GA 31410. To be effective, your cancellation must be postmarked by midnight, or hand delivered by midnight on _____ and must include all contract forms, membership cards and any and all other documents and evidence of membership previously delivered to you.

I understand that if I fail to pay the amount in this contract timely, I agree to pay all costs of collection to include attorney's fees in the amount of Fifteen percent (15.0%) of all sums due and owing.

Member's Responsibility: I am physically able to conduct this exercise program and have no known limitations, including physical and financial, that would prohibit me from fulfilling this contract. I recognize the facility, program and services are not a substitute for medical evaluation by trained health care professionals. I understand I am assuming the risks by the use of Hourglass' facility, program service and lifestyle change. All use of Hourglass' services and programs shall be undertaken at my own risk and Hourglass shall not be held liable for any injuries, accidents, or death arising now or in the future either directly or indirectly out of utilizing Hourglass' services or programs. I expressly release, discharge, waive, relinquish and covenant not to sue Hourglass, its members, managers,

employees, successors and assigns for any and all claims, demands, injuries or damages with respect to the use of Hourglass' facilities, services or programs. I expressly agree to hold indemnify and hold Hourglass harmless for any and all claims arising out of my use of the facilities. I release Hourglass, its management, staff, successors and assigns from any claim which may have occurred as a result of a known or unknown medical condition which I presently have or later develop. I am aware that the employees of this facility are not qualified to make medical decisions regarding my health or physical ability to perform this exercise program. It is my responsibility to contact my physician before beginning this program. It is additionally my responsibility to notify my physician immediately should I suffer any discomfort, become ill, injured, dizzy or experience any health problem.

NOTICE: State law requires that we inform you that should you (the buyer) choose to pay for any part of this agreement in advance, be aware that you are paying for future services and may be risking loss of your money in the event this health spa ceases to conduct business. Health spas do not post a bond, and there may be no other protections provided to you should you choose to pay in advance.

HIPAA: This authorization permits Hourglass Weight Loss & Fitness Centers, LLC to use and / or disclose individually identifiable health information about me to my health care provider. I also may receive communications from time to time based upon my health status. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Member Signature: _____ Hourglass representative: _____

Member Printed Name: _____ Date: _____