

Client number:					
Client's surname:					

Wellbeing programme agreement

Centre use only

Name

D.O.B.

Correct starter payment

Correct pro rata payment

Account details

Date joined

Corporate ID

Team member signature?

Is form signed by Client?

Is there a reference number on the DD form?

Email address completed?

DPA check?

Client No & type

Signature of team member_

Nuffield Health



Wellbeing pro	gramme d	agreement	Client number				
New Retu Transfer from centre	urning	Add on	Standard Monthly (3 month min commitment)	Discounted /	•	unted Prepaid	
1st applicant			Referred by				
Title		D.O.B					
Forename			Surname				
Email				I	Mobile		
Address							
Tel home			Postcode Tel work				
2nd applicant			Referred by				
Title		D.O.B	,	Client number			
Forename			Surname				
Email			comanic	,	Mobile		
Address				,			
Tel home			Postcode Tel work				
Terrionie			Tel WOIK				
Title 3rd applicant 4th applicant 5th applicant	e	Full name		D.O.B	Client No).	
Programme details							
Programme category		Monthly	Starter payment	Pro rata	Prepaid discounted	Total initial	
/ sub category		subscription		payment	payment	payment	
1		£	£	£	£	£	
2		£	£	£	£	£	
3		£	£	£	£	£	
4		£	£	£	£	£	
5		£	£	£	£	£	
Total amount of DD		£			Total paid on joining	£	
Programme start da Date of first Direct Debit:	te:			Payment method			
Minimum commitme	ent date:						
Corporate ID attached		National corporate		Corporate name			
f you are registered disal	oled or have any	•		•			
1. Terms and Conditions – Please changed from time to time by us. 2. Cupon the payment option that you have continue on a monthly basis. You may full terms and conditions for full details on a monthly basis with no discount. Y 7 of the full terms and conditions for full commitment. Please read section 7.9 of Please see section 4.4 of the full terms require at least one full calendar month 1 st applicant signature 2nd applicant signature	ommitment Period - e selected. 3. Standar v cancel at anytime but yo 4. Discounted Mon ou may cancel at anytim ther details. 5. Prepai of the terms and conditio and conditions for furthe	the minimum commitment period d Monthly Option – You com our agreement and payments wo thly Option – You commit to pr the but your agreement and paym d Discounted Option – You com so which refers to the ending/cor or details of how this may impact y	I is stated above and subscription mit to pay the monthly subscriptic in 'ft finish until your earliest commit ay the monthly subscription detail ents won't finish until your earliest commit to pay in advance a prora intinuation of the agreement. 6. Proo. 7. Cancellations – except	is are due throughout the comm of detailed above for a period of the the thing of t	itiment period, or prior to the commit of the full calendar months, after what one full calendar months notice. Pol calendar months of the agree at least one full calendar months raid. and 12 monthly subscriptions for a criptions will be reviewed and change.	ment period depend nich the agreement lease see section 7 greement will continuotice. Please see se 12 full calendar mon ged from time to time	
Use of my information			1	1st applicant	2nd applicant		
 X 1. Please cross the box if you DO 2. Please tick the box if you 3. Please tick the box if you 	wish to be contact	ed by us about our partne					

This Guarantee should be detached and retained by the payer.

The Direct Debit Guarantee



- This Guarantee is offered by all banks and building societies that take part in the Direct Debit Scheme.
 The efficiency and security of the Scheme is monitored and protected by your own bank or building society.
 If the amounts to be paid or the payment dates change Nuffield Health will notify you 10 working days in advance of your account being debited
- If an error is made by Nuffield Health or your bank or building society, you are guaranteed a full and immediate refund from your branch of the
- You can cancel a Direct Debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.



Please complete this Direct Debit and return to the address below. The Fountain Spa Fitness & Wellbeing Centre, Best Western Balgeddie House Hotel, Balgeddie Way, Glenrothes, Fife, KY6 3ET



Name and full postal address of your Bank or Building Society

of exercise or any other activity available at any of our centres.

Instruction to your Bank or Building Society to pay by Direct Debit

Reference

Originator's identification Number

2 5 8 1 2 6

	Postcode				
		Instruction to your Bank or Building Society Please pay Nuffield Health Direct Debits froi subject to the safeguards assured by the Dire	ect Debit Guarantee. I understar	nd that	
	Name(s) of Account Holder(s)	this instruction may remain with Nuffield He electronically to my Bank/Building Society.	alth and, if so, details will be pa	ssed	
ld here					E-14
		Signature (s)			_ Fold
	Bank/Building Society account number				
		Date			
	Branch Sort Code				
	Banks and Building Societies may not accept Dire	ect Debit Instructions for some types of account			
		, , , , , , , , , , , , , , , , , , ,			
Pre	e-exercise questionnaire		Client number		
	rtain medical issues may indicate that you should not take part in ex	•			
	ase tick the boxes below if any of the following medical issues apply		-		
_	proval to exercise. If any of the following medical issues apply st obtain your doctor's approval to exercise before we can permit you	-	your doctor's approv	al to exercise y	/OU
1110	si obidin your doctor's approvario exercise before we can permit yo	50 10 exercise in our cernies.	1st applicant name	2nd applican	nt name
1. \	You have a heart condition and your doctor has recommended that	you only exercise			
i	in a medically supervised programme				
	You have on one or more occasions lost consciousness or fallen ove	r as a result of dizziness			
	You experience unexplained chest pains at rest or while active	111			
	You have been diagnosed with a severe bone or joint problem that	could be made worse			
	by exercising You are currently being prescribed medication for high blood pressi	uro a boart condition or other			
	serious illness	ore, a near condition of other			
	You are pregnant or have given birth in the last three months				
<i>7</i> . T	There is another reason, not mentioned above, why you should only				
	supervised programme (e.g. uncontrolled diabetes or epilepsy)	exercise in a medically			
De	supervised programme (e.g. uncontrolled diabetes or epilepsy)	exercise in a medically			
			Signature	Signature	
If yo	eclaration ou have any questions regarding this Pre-Exercise Questionnaire plans member. If any of your answers to the above questions change of	ease speak to a The Fountain Spa r for any other reason you are	Signature	Signature	_
If yo	colaration ou have any questions regarding this Pre-Exercise Questionnaire plans member. If any of your answers to the above questions change of sure at any time whether as a result of your state of health you should	ease speak to a The Fountain Spa r for any other reason you are d exercise please seek the			_
If yo	eclaration ou have any questions regarding this Pre-Exercise Questionnaire plans member. If any of your answers to the above questions change of	ease speak to a The Fountain Spa r for any other reason you are d exercise please seek the	Signature	Signature Date	_
If you tea	colaration ou have any questions regarding this Pre-Exercise Questionnaire plans member. If any of your answers to the above questions change of sure at any time whether as a result of your state of health you should	ease speak to a The Fountain Spa r for any other reason you are d exercise please seek the g.			_

	programm						
New Transfer from cent	Returning tre	Add on	Standard Monthly (3 month min commitment)	Discounted (12 month min	Monthly commitment)		nted Prepaid
1st applicant			Referred by				
Γitle		D.O.B					
Forename			Surname		A A . I . I		
Email Autorea					Mobile		
Address			Postcode				
Tel home			Tel work				
2nd applicant			Referred by				
Title		D.O.B		Client number			
orename			Surname				
Email					Mobile		
Address			D				
Tallbaure			Postcode				
Tel home			Tel work				
	Title	Full name		D.O.B		Client No.	
3rd applicant						Cilotii i to.	
4th applicant							
5th applicant							
Programme de	etails						
Programme categ	jory	Monthly	Starter payment	Pro rata		discounted	Total initial
/ sub category		subscription £	£	payment £	£		£ payment
2		£	£	£	£		£
3		£	£	£	£		£
4		£	£	£	£		£
5		£	£	£	£		£
Total amount of D	D	£			Total pai	d on joining	£
Programme st	art date:			Payment method		, ,	
Date of first Direct	Debit:						
Minimum com	mitment date:						
Corporate ID atta	iched	National corporate		Corporate name			
f you are registere	ed disabled or have	any special requirements	of us speak to a team	member			
		ave read and understand the full terms a riod – the minimum commitment period					
upon the payment option th	hat you have selected. 3. Sta	undard Monthly Option – You common but your agreement and payments won	nit to pay the monthly subscription	on detailed above for a perio	d of three full calendo	ır months, after which	ch the agreement v
ull terms and conditions fo	or full details. 4. Discounted	I Monthly Option – You commit to pa anytime but your agreement and payme	y the monthly subscription detail	ed above for a period of 12	full calendar months,	after which the agre	eement will continu
7 of the full terms and cond	ditions for further details. 5. Pr	repaid Discounted Option – You conditions which refers to the ending/cont	mmit to pay in advance a prora	te payment (where applicab	le) and 12 monthly su	bscriptions for a 12	full calendar mon
Please see section 4.4 of th	ne full terms and conditions for	r further details of how this may impact yo	ou. 7. Cancellations – except				
equire ar least one full cale I st applicant signature		el but will not be cancelled before the end	Signed on behalf of The Foun	tain Spa			
2nd applicant signature			Printed name The Fountain Sp				
			Date				
Date							
Date Use of my information	n		1	lst applicant	2nd applicant		

This Guarantee should be detached and retained by the payer.

The Direct Debit Guarantee



- This Guarantee is offered by all banks and building societies that take part in the Direct Debit Scheme.
 The efficiency and security of the Scheme is monitored and protected by your own bank or building society.
 If the amounts to be paid or the payment dates change Nuffield Health will notify you 10 working days in advance of your account being debited
- If an error is made by Nuffield Health or your bank or building society, you are guaranteed a full and immediate refund from your branch of the
- You can cancel a Direct Debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.



Please complete this Direct Debit and return to the address below. The Fountain Spa Fitness & Wellbeing Centre, Best Western Balgeddie House Hotel, Balgeddie Way, Glenrothes, Fife, KY6 3ET



fitness & wellbeing

Name and full postal address of your Bank or Building Society

Instruction to your Bank or Building Society to pay by Direct Debit

Originator's identification Number 5 8 1

		Keference			
	Posicode Posicode				
		Instruction to your Bank or Building Society			
		Please pay Nuffield Health Direct Debits fro subject to the safeguards assured by the Dir			
	N. A. C. H. H. A.	this instruction may remain with Nuffield He electronically to my Bank/Building Society.	alth and, if so, details will be pa	ssed	
	Name(s) of Account Holder(s)	, , , ,			
old here		Signature (s)			_ Fold h
	Bank/Building Society account number	Date			
		Dale			
	Branch Sort Code				
	Banks and Building Societies may not accept Direct	ct Debit Instructions for some types of account			
D.	e-exercise questionnaire		Client number		
	•				
	rtain medical issues may indicate that you should not take part in ex	•	,		
	ase tick the boxes below if any of the following medical issues apply	-	-		
_	proval to exercise. If any of the following medical issues apply t st obtain your doctor's approval to exercise before we can permit yo		your doctor's approv	al to exercise yo	50
1110	si obidin your doctor's approvanto exercise before we can permit yo	ou lo exercise in our cernies.	1st applicant name	2nd applicant	name
1. `	You have a heart condition and your doctor has recommended that	you only exercise			
	n a medically supervised programme	,			
	You have on one or more occasions lost consciousness or fallen over	as a result of dizziness			
	You experience unexplained chest pains at rest or while active				
	You have been diagnosed with a severe bone or joint problem that o	could be made worse			
	by exercising	and the same and the same and the			
	You are currently being prescribed medication for high blood pressu serious illness	ire, a heart condition or other			
	You are pregnant or have given birth in the last three months				
	There is another reason, not mentioned above, why you should only	exercise in a medically			
	supervised programme (e.g. uncontrolled diabetes or epilepsy)	,			
De					
	eclaration				
If v		agea speak to a The Fountain See	Signature	Signatura	
	ou have any questions regarding this Pre-Exercise Questionnaire ple		Signature	Signature	
tec	ou have any questions regarding this Pre-Exercise Questionnaire ple m member. If any of your answers to the above questions change or	for any other reason you are	Signature	Signature	
tec	ou have any questions regarding this Pre-Exercise Questionnaire ple our member. If any of your answers to the above questions change or sure at any time whether as a result of your state of health you should	for any other reason you are exercise please seek the	Signature	Signature Date	
ted uns ap	ou have any questions regarding this Pre-Exercise Questionnaire ple m member. If any of your answers to the above questions change or	for any other reason you are exercise please seek the			_

by me are correct and not misleading. I know of no reason why I should not participate in any form

of exercise or any other activity available at any of our centres.