

Wellness & Aftercare

HOW TO ENROLL OR RENEW MEMBERSHIP

Several Wellness programs are provided through Pomona Valley Hospital Medical Center and the Charles M. Magistro Physical Therapy and Rehabilitation Center. Although our Wellness programs may be located at one of our rehabilitation facilities, **these programs are not formal rehabilitation**. Wellness programs focus on an individual's general health and fitness—as opposed to treatment for recovery from a specific injury, disease or illness. Wellness sessions are supervised by licensed Physical Therapists, licensed Physical Therapy Assistants, Physical Therapy Aides, Exercise Physiologists, or Pulmonary Therapists. Participants are often former rehab patients who want ongoing “aftercare” support during their transition to an independent fitness program, however, anyone may join as a “wellness” member. All of our Wellness Programs are CASH-PAY and the participant's medical insurance will not be billed. Wellness visits are good for one year from the date of clearance to enroll and are NON-REFUNDABLE.

PATIENTS TRANSITIONING TO WELLNESS and RENEWING WELLNESS MEMBERS will need to have their physician sign the CLEARANCE TO PARTICIPATE (below) indicating their medical status—as we know it—has not changed within the last year. This clearance will be good for one year from the date it is signed.

CLEARANCE TO PARTICIPATE FORM:

Participant's Name (*printed*): _____ DOB: _____ Phone: _____

Participant's Signature: _____ Date: _____

Parent/Guardian Signature (*if participant is under 18*): _____

I acknowledge this patient's medical condition has improved sufficiently to allow participation in the Wellness exercise program designated below at the PVHMC Rehabilitation Department.

Aquatic Wellness Cardiovascular-Pulmonary Wellness Gym Wellness

Physician's Name (*printed*): _____

Address: _____ Phone: _____

Physician's Signature: _____ Date: _____

ALL OTHER NEW WELLNESS PARTICIPANTS will need to have their physician fill out the PRESCRIPTION order (below) for us to perform a Wellness Evaluation to determine if the individual is medically safe to participate. This evaluation will be covered by insurance. Once enrolled, Wellness sessions will be CASH-PAY and medical insurance will not be billed.

PRESCRIPTION ORDER FOR A WELLNESS EVALUATION: (*all fields must be completed*)

Participant's Name (*printed*): _____ DOB: _____ Phone: _____

Provide a Wellness Evaluation for the program indicated below: _____ Diagnosis: _____

Aquatic Wellness Cardiovascular-Pulmonary Wellness Gym Wellness

Physician's Name (*printed*): _____ NPI # _____ UPN # _____

Address: _____ Phone: _____

Physician's Signature: _____ Date: _____