Lifestyle Program Application

525 Abundant Life Way, Sawyerville, AL 36776 | 334-624-2552 (office)| 855-301-8116 (fax) | ALWI@napsoc.org
www.abundantlifeway.org

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Lifestyle Program FAQs

WELCOME!

Thank you for your interest in being a Lifestyle Guest at the NAPS Abundant Life Wellness Institute! We are excited that you would consider us to assist you on your journey to a more abundant life. We have included information about the program, as well as forms that we'd like you to fill out so that we can have the information we'll need from you and your doctor(s). This will help us to make the necessary preparations to customize your treatment session and help meet your specific needs.

WHAT IS INCLUDED IN THE PROGRAM?

The session includes private guestrooms with full private bathrooms, meals, doctor consultations, personal lifestyle coach, hydrotherapy treatments and massages during weekdays, educational health talks and videos, cooking classes, fitness training, and more. Upon your departure, you will be given a personalized packet of tools that will equip you to continue the new lifestyle you will have acquired here so that you can take control of your health. Because of the intensity of the program during the week, the weekends will be more relaxed. Wireless internet is available, along with Christ-centered television programming and news.

WHAT SHOULD I PACK?

In the spring it can be quite cool; in the fall it can be very warm. Plan to wear casual clothing for classes and also bring some outdoor clothing for activity/exercise periods. Laundry facilities are available, but please bring your own detergent and queen-sized linens.

- ☐ **all medications**
- ☐ related current medical records (if available)
- ☐ bathing suit/trunks
- ☐ bathrobe
- ☐ warm coat (during cold seasons)
- ☐ nightgown/pajamas
- ☐ queen-sized bedding
- ☐ toothbrush
- ☐ toothpaste
- ☐ detergent
- ☐ deodorant
- ☐ 1-2 sets of dress clothes
- ☐ comfortable walking shoes
- ☐ flip flops/shower shoes
- ☐ soap
- ☐ towels
- ☐ washrags
- ☐ umbrella
- ☐ notebook
- ☐ pens
- ☐ Bible
- ☐ flashlight
- ☐ water bottle

WHERE IS ALWI LOCATED?

Our address is *525 Abundant Life Way, Sawyerville, AL 36776*. Though it can be found via Google Maps, it may not appear on all GPS systems/apps. In that case, you may use *6228 County Rd 28, Sawyerville, AL 36776*, and turn onto our campus through our main entrance is on County Road 35, with a large, light blue sign with our name on it. Once you have registered for a treatment session, we will send you a more detailed map to ALWI. If problems do arise in finding us, call us at 334-624-2552 or 334-624-2557.

WHAT TIME ZONE IS ALWI IN?

ALWI and the surrounding counties are on Central Time.

WHAT ABOUT CHILDREN?

In order for us to be totally focused on your care and the care of the other guests, we kindly ask that you make arrangements for the care of your child(ren) prior to your arrival.

WHEN DO I ARRIVE AND DEPART?
For 10-Day and 14-Day sessions, lifestyle guests should arrive by noon on the first day of the session (usually a Friday) and plan to leave by noon on the last day (usually a Sunday for 10-Day programs or Thursday for 14-Day programs), after an exit interview with the doctor. For 1-Day Sessions, guests should plan to arrive at 6:30 am and leave by 5:30 pm. Special arrangements must be made for early arrival or late departure. Advance notification of such intentions is appreciated and regular guest prices will be charged. ***This information is subject to change.***

WHAT IF I COME BY COMMERCIAL TRANSPORTATION?
Please contact our Lifestyle Center for details.

WHAT ARE THE RESIDENTIAL RULES FOR ALWI?

- No loud music.
- Always be fully clothed when outside of your guest room.
- No drugs, cigarettes and alcohol on the campus.
- No food kept in rooms.
- Male–Female separation in guestrooms unless accompanied members of your family or a counselor/coach/medical personnel.

WHAT IS THE LENGTH AND THE COST OF PROGRAM?

Session Options	Lifestyle Guest	Lifestyle Supporter
10-Day Lifestyle Package	$2500	$1250
14-Day Lifestyle Package	$3500	$1750
1-Day Lifestyle Package	$200	$100

Sessions Include:	10-/14-Day Guests	10-/14-Day Supporter	1-Day Sessions
Private guestrooms with full private bathrooms (Supporters may share room with their Lifestyle Guest)	X	X	
Delicious, nutritious meals	X	X	Breakfast and Lunch
Herbal teas	X	X	
Educational health talks and/or videos	X	X	X
Fitness training	X	X	
Cooking class(es) & Recipe Packet	X	X	X
Guided nature walks	X	X	X
Wireless internet	X	X	
Christ-centered satellite television programming and news	X	X	
Laundry facilities	X	X	
Physician consultations	X		
Complete Physical Exam	X		
Lab work (if needed)	X		
Personal Lifestyle Coach	X		
Hydrotherapy treatments	X		X
Massages	X		X
[illegible]			Health Information

To secure a place in your 10-Day or 14-Day Program, 10% of the full cost must be paid one month in advance. For the 1-Day Program, a down-payment of $50 must be paid two weeks in advance. For all programs, the balance should be paid upon the arrival at registration. All payments may be made by check, money order, cash, or credit card (online or by phone). Contact the center if you have any questions.

WHAT ARE THE DATES FOR YOUR PROGRAMS?

Due to limited space, please schedule your visit as early as possible, and contact us for information about the availability of specific dates or visit the abundantlifeway.org for specific dates.

Please call for updates or for available dates of the 1-Day Sessions.

MORE QUESTIONS?

Call us at 334-624-2552 or 334-624-2557, or e-mail us alwi@napsoc.org. We look forward to having you!

PHYSICIAN INFORMATION

Primary Care Doctor: ______________________________ Tel: (____) ______________

Address: ______________________ City / State / Zip: ______________________

Referring Doctor: ______________________________ Tel: (____) ______________

Address: ______________________ City / State / Zip: ______________________

Are you currently receiving treatment for any medical condition or under the care of any other physician other than your primary care physician or the referring physician? Yes No

Name of Physician: __________________________ Tel: (____) ______________

What are you being treated for: ______________________________________

INSURANCE (IF APPLICABLE)

Primary Insurance: ____________________________

Name of person who carries the insurance: First ________________ Last ________________

Date of Birth of person carrying insurance: ______________ Social Security Number: ______________

Secondary Insurance: ____________________________

Name of person who carries the insurance: First ________________ Last ________________

Date of Birth of person carrying insurance: ______________ Social Security Number: ______________

GUEST PERSONAL NEEDS

What health concerns would you like to address while you are here?

- □ *Allergies*
- □ *Arthritis*
- □ *Asthma*
- □ *High Blood Pressure*
- □ *Diabetes (Type 1)*
- □ *Diabetes (Type 2)*
- □ *Smoking*
- □ *Stress Management*
- □ *Weight Management*
- □ *Other: ______________*
- □ *Other: ______________*

Please circle Yes or No for the following questions.

Do you need assistance with any of the following:

- *Bathing* Yes No
- *Dressing* Yes No
- *Walking* Yes No
- *Eating* Yes No
- *Standing Up* Yes No
- *Sitting Down* Yes No
- *Getting into Bed* Yes No
- *Urination/Defecation* Yes No

Do you use any of the following:

- *Walker* *Yes* *No*
- *Cane* *Yes* *No*
- *Wheelchair* *Yes* *No*
- *Shower Chair* *Yes* *No*

Other Questions:

- *I am able to take care of bodily functions at night without assistance.* *Yes* *No*
- *I am able to walk 2 blocks round trip on graveled roads without assistance.* *Yes* *No*
- *For actions above that I am unable to accomplish on my own, I will be accompanied by the support person listed below should I be accepted into the program.* *Yes* *No*

Support Person: ______________________ *Relationship:* ______________________

Please select the type of session you would like to attend (please contact the offices for possible schedule changes:

- ☐ *10-Day Session*
- ☐ *14-Day Session*
- ☐ *1-Day Session*

Please indicate your desired date(s):

- *Option 1:* ______________________
- *Option 2:* ______________________
- *Option 3:* ______________________

GUEST SIGNATURE

1. *I understand that I am financially responsible for any balance.*
2. *I understand that I am responsible for informing the receptionist of any changes in address or medical information.*
3. *I understand that I may be required to provide a referral from my primary care physician (PCP).*
4. *I authorize release of my medical information to the pertinent insurance companies or third-party carriers necessary to process claims or obtain medical information.*

Signature: ______________________ Date: ______________________

Relationship to Guest: ______________________

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New Lifestyle Guest Medical History Form

Patient Name ______________________ Today's Date ____________

Age ____ Birth date ________ Date of last physical examination ________ Referring Physician ____________

What is your reason for visit? ______________________________

SYMPTOMS

Check (√) conditions your currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain/ weakness/numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Blood Clots
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Murmur
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Vaginal discharge

Date of last period ________
Date of last Pap Smear ________
Have you had a mammogram? ________
Are you pregnant? ______
Number of children _____

CONDITIONS

Check (√) conditions you currently have or have had in the past year.

☐ Epilepsy/Seizure disorder	☐ Stroke	☐ Appendicitis	☐ Diabetes
☐ Multiple Sclerosis	☐ Asthma	☐ Crohn'sDisease	☐ Goiter
☐ Migraine Headaches	☐ Bronchitis	☐ Hepatitis	☐ Thyroid Problems
☐ Alcoholism	☐ Emphysema/COPD	☐ Hernia	☐ Anemia
☐ Psychiatric Care	☐ Pneumonia	☐ Irritable Bowel	☐ Bleeding Disorder
☐ Cataracts	☐ Tuberculosis	☐ Liver Disease	☐ Breast Lump
☐ Glaucoma	☐ Heart Disease	☐ Ulcerative Colitis	☐ Cancer
☐ Blood Clots	☐ Heart Attack	☐ Ulcers, Stomach	☐ Herpes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Prostate Problem	☐ HIV Positive
☐ Pulmonary Embolism	☐ High Cholesterol	☐ Kidney Failure	☐ Arthritis
☐ Rheumatic Fever	☐ Pacemaker	☐ Kidney Stones	☐ Gout

Medications- List all medication you are currently taking with their dosage:	Allergies to Medications:

Pharmacy Name	Pharmacy Telephone Number

Family History – Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis/Gout	
Mother					Aortic Aneurysm	
Brothers					Blood Clots	
					Cancer	
					Chemical/ETOH dependency	
					Diabetes	
					Heart Disease/Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Peripheral Vascular Disease	
					Varicose Veins	
					Other	

Hospitalizations/ Surgeries/ Pregnancies

Year	Hospitalization or Serious Illness/Injuries	Reason for Outcome
Year of Birth	**Sex of Birth**	**Complication if any**

Health Habits

Check (√) Which substances you use and describe how much you use.

	Substance	
	Caffeine	
	Alcohol	___ How much? ___ How often?
	Drugs	
	Tobacco Year Quit	___ How many years? ___ Packs per day?

Occupational

Check (√) if your work exposes you to the following

	Stress		Heavy Lifting
	Other (list)		Hazardous Substances (list)

What is (was) your Occupation?

Have you ever had a blood Transfusion?

☐ **Yes** ☐ **No**

If yes, please give approximate dates

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_________________________ Signature

_________________________ Date

Release of Liability

(Read Carefully)

In exchange for participation in the wellness program organized by the National Association for the Prevention of Starvation (NAPS) and the Abundant Life Wellness Institute (ALWI), of 525 Abundant Life Way, Sawyerville, AL 36776 and/or use of the property, facilities and services of NAPS, I agree for myself to the following:

1. I agree to observe rules and guidelines of the program listed below.
   Please refrain from the following while participating in the Wellness Center program:
   - *Smoking*
   - *Alcohol*
   - *Loud music*
   - *Nudity*

2. I recognize that there are certain inherent risks associated with the above program and I assume full responsibility for personal injury to myself, and further release and discharge NAPS or ALWI for injury, loss or damage arising out of my use of or presence with NAPS or ALWI, whether caused by the fault of myself, NAPS, ALWI or other third parties.

3. I agree to indemnify and defend NAPS or ALWI against all claims, causes of action, damages, judgments, costs or expenses, including attorney fees and other litigation costs, which may in any way arise from my participation or presence on campus or during the program.

4. I consent to and authorize NAPS or ALWI personnel or their designee to take whatever reasonable steps he/she deems necessary in order to provide emergency medical care. I further agree to allow transportation of myself to a medical facility by ambulance or other commercial emergency vehicle.

I have read this document and understand it.

____ ______/______/_______

Signature of Participant (parent in the event of a minor) Date

____

Printed Name of Participant

In case of an emergency call: ______________________________ ________________

Name of Emergency Contact Relationship

Phone (______) ________-______________

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REQUEST FOR RELEASE OF PATIENT INFORMATION

PATIENT INFORMATION	**NAME:** ________ **DATE OF BIRTH:** ________ **Address:** ________ **Day Phone:** ________ **City:** ________ **State** ________ **Zip:** ________
Clinic/Hospital/Health Care Provider – (*Who* has the information you want released?) **Please list the specific Hospital and/or clinic.**	**NAME:** ________ **Address:** ________ **Day Phone:** ________ **City:** ________ **State** ________ **Zip:** ________
Receiving Party (*Where* do you want the information sent? *Who* may have the information?)	**NAME:** ABUNDANT LIFE WELLNESS INSTITUTE **Attention to:** MARLO E. PAUL, MD **Address:** 525 ABUNDANT LIFE WAY **Day Phone:** 334-624-2553 **City:** SAWYERVILLE **State** AL **Zip:** 36776 **Fax Number** 8553018116
Information to be Released (*What* do you want sent or released? Check the appropriate box.)	Routine Record Sets **(indicate date(s) of service** ________) ☐ Clinic (office visit, lab, radiology, medicines, immunizations) ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) ☐ Copies of Films/Images ☐ ***Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.) Only records types checked below: ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ Medication records ☐ History & physical exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Consultations ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Substance abuse records ☐ Chemical dependency/ Substance abuse records ☐ Progress notes/clinic notes ☐ Mental health records ☐ Pathology slides/blocks ☐ Other records specify record type(s) ________ OPTIONAL Limits: **Disclose only records related to following:** Date(s) of service/: ________ Injury or illness: ________
Release Instructions (*How* and *When* do you want the information?)	**Date information is needed:** ________ **Release Method / Format requested: (check one)** ☐ *Paper* ☐ *Fax*
Purpose of Release (*Why* is it needed?)	☐ **Personal use or review** ☐ **Continuing care** ☐ **Transfer of care** ☐ **Other*** ________

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: ________

This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. A photocopy/fax of this authorization will be treated in the same way as an original. The Abundant Life Wellness Institute will not redisclose your private health information, whether received from you or from a third-party (written or electronic), or acquired during your treatment sessions here, without your written consent.

Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

________ ________ ________

Patient/Legal Guardian Signature | Date | Authority to act on behalf of patient (attach document)

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EXERCISE CLEARANCE FORM

Dear Doctor:

Your patient, ____, wishes to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance. After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize Dr. ____ to release to the **NAPS Abundant Life Wellness Institute (ALWI)** health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Patient's signature ______________________________________ Date ________________________

Physician's Recommendations

☐ I am not aware of any contraindications toward participation in a fitness program.

☐ I believe the applicant can participate, but urge caution because: ______________________________
____

☐ The applicant should not engage in the following activities: ______________________________
____

☐ I recommend the applicant **not** participate in the above fitness program.

Physician's Signature ______________________________________ Date ____________________

Physician's Name (print) ____________________________________ Phone (_____)____________

Address ______________________________________ City ______________ State __________

Zip ____________ Fax (_____)____________

NAPS Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- promotional presentations
- educational presentations or courses
- informational presentations

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public promotional setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name____

Signature___________________________ Date___________________________

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature____________________ Date___________________________