LIGHTSOURCE CHIROPRACTIC

Family Wellness Plan

80 visits for a family of 2 or more to share over 12 months.

Pay Monthly

Save 10% ($560)

Great option for those who can't pay in full but still want to benefit from savings.

Down payment of 20%
11 monthly payments
Per visit fee: $63

All re-evaluations included in plan.

Down Payment: $1008
Monthly Installment: $366.44

Pay In Full

Save 15% ($840)

Most cost effective plan we offer.

Per visit fee $59.50

All Re-evaluations included in plan.

One Time Payment
$4760

Pay Per Visit

No savings

For those that are not ready to invest financially in their chiropractic plan.

Plan can be purchased at any time.

Re-evaluations billed at $90 each.

$70 per visit

Patients not using their insurance for direct payment will be enrolled in Chirohealth USA, our discount network. Fee for this is $49 per year for the family.

	PLAN	@ due today	Monthly installments
☐	Pay in full		
☐	Pay monthly		
☐	Pay per visit		

Benefits of a plan:

Major financial savings
Discounted new patient exams for immediate family members
Unlimited wellness workshops (some include dinner for you and a guest)
Complimentary progress exams as needed

What is not included in the plan:

Any guarantee of a cure for any illness or disease
Any additional services or products other than a chiropractic spinal adjustment
Diagnosis and treatment of conditions other than a vertebral subluxation

Payment Methods Accepted:

Health Savings, Flexible Spending, Cash, Check, Credit

Financial Agreement:

I have read and understand this agreement. Should I need to discontinue care before the end of the term, all visits will be calculated on a "per visit" basis of $70 per visit. I will either (a) be responsible for any outstanding balance for services already received at $70/visit or (b) receive a refund for services not yet received. Account balances over 30 days will be charged to my credit card unless prior arrangements have been made. If paying in monthly installments, we ask that your credit card be kept on file. No credit is given for vacations, sabbaticals, or other interruptions in office visits. Should any of the conditions of this agreement change, one month written notice is required.

_____ _____ _____

Practice Member Name (Print) **Practice Member Signature** **Date**

Family Members on this plan_____

Plan begins on: _____ Plan expires on: _____

Type of card_____ Credit Card #_____ Exp_____ CSV_____