LIGHTHOUSE LIFE CARE
MEMBERSHIP AGREEMENT

PATIENT NAME: ____ **PATIENT(S) FILE NUMBER**_______________________________

STREET ADDRESS: ________________________________**CITY:** ____________________________ **STATE** _________ **ZIP** ____________

HOME PHONE: (______) __________________________ **WORK PHONE:** (______) _______________________________

DATE OF BIRTH(S): ___________________________________**HOUSEHOLD MEMBER(S) TO BE COVERED:** ________________________

FIRST TIME MEMBERSHIP? ______ **OR PREVIOUS MEMBER** ______ **(PLEASE CHECK ONE)**

WHICH MEMBERSHIP ARE YOU PURCHASING?

ONE YEAR SINGLE MEMBERSHIP ($35.00) ______ **ONE YEAR SINGLE PLUS ONE MEMBERSHIP ($ 50.00)** ______

ONE YEAR FMLY HOUSEHOLD MEMBERSHIP ($65.00) ______ **TWO YEAR FAMILY HOUSEHOLD MEMBERSHIP ($110.00)** ______

METHOD OF PAYMENT: CASH ______ **CHECK** ______ **(CHECK NO.)** ______ **CREDIT/DEBIT CARD** _________

CREDIT/DEBIT CARD # (LAST FOUR DIGITS ONLY) ____________________________ **EXPIRATION DATE** __________

MONTH TO START: JAN FEB MARCH APRIL MAY JUNE JULY AUG SEPT OCT NOV DEC 20_______ (CIRCLE MONTH TO START)

Memberships Offered:

1 Year Single Membership	*$ 35.00*
1 Year Single Plus One Membership	*$ 50.00*
1 Year Family Household Membership	*$ 65.00*
2 Year Family Household Membership:	*$ 110.00*

Services Provided With Membership:

Chiropractic Adjustments (Adults)	**$ 30.00**
Chiropractic Adjustments (Child)	**$ 26.00**
X-rays (per view)	**$ 30.60**
Exams	**$ 20.00**
Therapy (for first therapy) i.e. massage	**$ 14.00**
Each additional therapy i.e. whirlpool/EMS/Decompression	**$ 2.00 discount**
Nutrition Supplements	**10 % discount**
Biofeedback Services	**10 % discount**

Prices listed above DO include the 2% Minnesota Care Tax which is added to all services.

1. I agree to participate in the **LIGHTHOUSE LIFE CARE PROGRAM** offered at this clinic.
2. In accordance with the terms of this program, the cost of my care is being reduced in exchange for prompt personal payment at time of service, and the elimination of all tasks associated with insurance billing and the financial management of my account. I further understand, that as a result, this office **does not** complete claim forms, or write reports for submission to any insurance company or interested third party payer, and **at no time** will this practice respond to any requests made by either my insurance company, or a third party administrator, seeking additional information to process a claim, unless the request acknowledges a cost for this service, and payment is tendered.

3. I agree to pay either a one year or two year membership fee to start the **LIGHTHOUSE LIFE CARE PROGRAM.** All memberships expire on the 1st day of the contracted month. If I decide to terminate my **LIGHTHOUSE LIFE CARE PROGRAM** early for any reason, I agree the membership fee is not refundable.

4. I acknowledge that the **LIGHTOUSE LIFE CARE PROGRAM** prices are current at the time of agreement and are subject to change without notice.

5. I acknowledge that the **LIGHTHOUSE LIFE CARE PROGRAM** I wish to participate in imposes 'situational restrictions' which could cause my care to be suspended or terminated should one arise. It has been explained to me and I understand and agree to immediately notify the clinic should any of the following circumstances or situations arise:

   In the event, I **sustain a new injury** or have an accident. Under these circumstances I realize I may experience new symptoms and or a new problem may arise which could impede my ability to recover from my current condition and therefore I understand that it is important to assess any new symptoms to determine how they may effect my current and future health status and whether there is a need to modify my current care plan. Once my new symptoms and condition(s) are diagnosed and or resolved my **LIGHTHOUSE LIFE CARE PROGRAM** will resume.

6. Therefore, in as much as the clinic has discussed the terms of this agreement and I have conveyed my complete understanding of all payment options, after careful consideration, I agree to make personal payment for the recommended care.

________________________ ____________ ________________________ ____________

(Patient's Signature) ***(date)*** ***(Clinic Authorized Signature)*** ***(date)***

Revised 1/2016