TLC Chiropractic Center Health and Wellness Program

Creating Affordable Cash Chiropractic Care

PURPOSE

Our purpose is to create a simple cash alternative program that makes chiropractic care an affordable and accessible option to everyone who chooses to access it.

CASH PAYMENT= SIMPLICITY AND SAVINGS

By eliminating the high cost and time consuming efforts of insurance billing, your provider saves time and money. As an Adjusted America, Inc. provider, he is willing to pass this savings on to you.

MEMBERSHIP OPTIONS

* One year household membership: $100.00
* Two year household membership: $150.00

A household is defined as up to two adults and any dependent children up to age 26 who are either living at home or are in school full time.

COST OF SERVICES WITH MEMBERSHIP

Each provider on the program must set his office fees within the range as outlined below. The fee can vary from office to office but must be within the established ranges. This flexibility in the program allows for variances in geographical regions and other factors.

Chiropractic Adjustments (Adults): $17.00-45.00
Chiropractic Adjustments (Child/Sr. Citizen) $15.00-45.00
X-rays (per view) $20.00-60.00
Therapy (per therapy) $ 5.00-20.00
Exams: $15.00-70.00

OPTIONAL ADDITIONAL SERVICES

Massage Therapy 10% discount
Rehab Services 20% discount
Nutrition Items 10% discount
Foot Bath Detox 10% discount
Other Miscellaneous Discipline Providers 20% discount

APPLICATION FOR MEMBERSHIP

1. NAME:_____

ADDRESS: _____

CITY: _____STATE _____ZIP _____

HOME PHONE: (_____)_____WORK PHONE: (_____) _____

EMAIL ADDRESS (for renewal notice & confirmation purposes only) _____

2. DATE OF BIRTH: _____ SOC. SEC. # : _____

3. OTHER HOUSEHOLD MEMBERS TO BE COVERED:_____

4. FIRST TIME MEMBER? _____ or PREVIOUS MEMBER? _____ (Check one)

5. WHICH MEMBERSHIP WOULD YOU LIKE TO PURCHASE?

A. ONE YEAR HOUSEHOLD MEMBERSHIP ($100.00) _____

B. TWO YEAR HOUSEHOLD MEMBERSHIP ($150.00) _____

6. METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT/DEBIT CARD _____
Credit/Debit Card #_____Expiration Date _____
If using credit/debit card sign here for authorization to bill your card the amount you have designated above.
Signature _____

7. MONTH TO START MEMBERSHIP: _____ YEAR: _____
(Circle month to start)

8. DOCTOR OFFICE YOU GO TO: 2170 W Lomita Blvd, Lomita, CA 90717 Provider License# DC28810

Rules of Participation

1. Work related injuries, car accident care, or other personal injury care where third party liability exists cannot be billed at the fee schedule of this program unless the liable insurance company is willing to pay your membership fee during your course of treatment, is willing to pay for all services at the time they are rendered (or prepay), and is also willing to abide by the paperwork restrictions outlined by this program. You may suspend your membership during the course of such treatment (which suspends it for all household members), or keep it active for other household members to continue to use.

2. PAPER WORK RESTRICTION: With this membership there can be no insurance billing, no insurance questionnaires responded to; no reports written or any form of regular patient billing.

3. PAYMENT REQUIREMENTS: No refunds will be given for any reason for your membership once purchased. All payment for your care at your provider office must be made at the time of service or be prepaid. Any other arrangements must be specifically approved in writing from your provider.

4. GUARANTEE: There can be no guarantee that any illness, injury, or disease can be prevented or cured by participating in this program. In addition, Consumers should use their own evaluation methods in choosing their health care providers. By participation in this program, I release Laudig Chiropractic Center from any liability involving my care and relationship with my provider.