WELLNESS MADE AFFORDABLE

Purpose: The purpose of our Wellness Made affordable (WMA) program is to make chiropractic care at Smith Chiropractic convenient and affordable.

Eligibility: Those qualified for membership must be recommended by Dr. Smith and must have agreed to and completed the terms of this agreement.

Exclusions: Care in the WMA program is NOT covered by insurance companies. Therefore, since it is **ineligible for insurance reimbursement, no insurance paperwork will be provided.** This program does not cover any (1) work-related injuries, (2) automobile accidents, (3) personal injury claims, or (4) any other condition with a third-party financial liability.

Plan Flexibility: A WMA member may come in and out of the WMA program as needed. However, any WMA treatments a member receives will not be eligible for insurance reimbursement at a later date since the criteria for reimbursement (e.g. detailed exam findings with diagnosis) will not have been generated.

Pretax Health Care Savings Plans: If you participate in a pretax health care savings plan, such as a Flexible Spending Account (FSA) or Health Savings Account (HSA), it is important you review the plan's parameters for reimbursement. A WMA transaction record can be provided to you upon request. This record does not provide an insurance diagnosis or procedure codes.

FEES
There is a one-time membership fee of $10 per individual.
Initial New Patient visits are $85
Each Chiropractic adjustments rate is $45 and adjunctive therapy if needed is $15.

Membership is non-transferable.
You will be notified by our office of any changes to our WMA program.

WMA members must agree to pay in accordance with the following criteria:

- I agree to pay by cash, check, or credit card prior to or at the same time services are rendered. Otherwise, a surcharge or $15 (adjustment only) or $20 (adjustment and therapy) may be added to my charges.
- There is no guarantee that any illness, injury, or disease can be prevented or cured by participation in this program.

I have read and understand the terms of this agreement.

_____
Patient's Name Printed

_____ _____
Patient's/guardian's signature Date

_____
Office representative initials