12-WEEK CANDIDA PROGRAM PROTOCOL

PATIENT NAME: ***DATE STARTED PROGRAM:***

Initial Evaluation	□ Paperwork doubled check for ALL information
Date:	□ Take Symptom Survey
	□ Close
	□ Products given and explained
	□ Daily Checklists explained
	□ Contract and Product forms signed by patient and employee
	□ Record patient's weight
	□ Take "Before" picture
	□ Record "Before" body measurements
	□ Verify next scheduled visit
VISIT 2	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 3	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 4	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 5	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit

VISIT 6	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 7	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 8	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 9	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 10	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit
VISIT 11	□ Evaluation to review journal and progress
Date:	□ Record patient's weight
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Verify next scheduled visit

VISIT 12	□ Follow up Symptom Assessment
Date:	□ Evaluation to review journal, progress, and to determine patient's next steps
	□ Exercise
	□ Sauna
	□ Body Wrap
	□ SMT (During Body Wrap)
	□ Ask for testimonial
	□ Record patient's weight
	□ Take "After" picture
	□ Record "After" body measurements
	□ Offer Maintenance Program
	□ Schedule next evaluation a month out to review progress after program
VISIT 13	□ Follow up Symptom Survey
Date:	□ Evaluation to review progress and to determine patient's next steps

*Staff must initial everything they complete.

12-WEEK CANDIDA PROGRAM EVALUATIONS

Patient Name:_____ Age:_____ Height:_____ Anticipated Program Start Date:_____

Visit #	Visit #	Visit #	Visit #
Date:	**Date:**	**Date:**	**Date:**
Weight:	**Weight:**	**Weight:**	**Weight:**
Digestion:	**Digestion:**	**Digestion:**	**Digestion:**
Elimination:	**Elimination:**	**Elimination:**	**Elimination:**
Sleeping Habits:	**Sleeping Habits:**	**Sleeping Habits:**	**Sleeping Habits:**
Energy Levels:	**Energy Levels:**	**Energy Levels:**	**Energy Levels:**
Evaluation:	**Evaluation:**	**Evaluation:**	**Evaluation:**
EWOT:	**EWOT:**	**EWOT:**	**EWOT:**
Sauna:	**Sauna:**	**Sauna:**	**Sauna:**
Body Wrap:	**Body Wrap:**	**Body Wrap:**	**Body Wrap:**
SMT:	**SMT:**	**SMT:**	**SMT:**

12-WEEK CANDIDA PROGRAM

PRODUCTS

Patient Name: _____ Date: ___/___/___

✓	# of Units	Products Included in Program:	Price:
	1	Antioxidant	$36.00
	2	Appetite Appeaser	$48.00
	4	Body Purifier	$92.00
	5	Digestive Enzyme Blend	$125.00
	1	Evening Primrose Oil	$40.00
	1	Flax Seed Oil	$30.00
	5	Fiber Blend	$125.00
	4	Intestinal Cleanser	$92.00
	2	Cellulite Cleanse	$48.00
	1	Liquid Calcium	$25.00
	1	Anti-Cellulite Lotion	$25.00
	1	Exercise Gel	$29.00
	2	Mixture Bottles (For the Lemonade Detox)	$8.00
	2	Multivitamin/Mineral	$64.00
	2	Nutritional Shake (up to 3 scoops a day)	$100.00
	4	Probiotic Blend	$112.00
	1	Vitamin D	$15.00
		Total Price	$1,014.00

I have checked off (✓) the products above and I verify that all of these products are included in this packet:

By signing this, I acknowledge that I have been given all of the products that I need for the duration of this program. If I choose to take more supplements on some days, I know that I will have to purchase more if I run out. ***In addition, to complete the program, you may need to purchase additional Nutritional Shakes. Though we provide you with two Nutritional Shakes to start with, we want you to be able to pick your own flavors from there on out.***

_____ _____
Signed Date
(Patient Signature)

_____ _____
Signed Date
(Employee Signature)

12-WEEK CANDIDA PROGRAM

CONTRACT

	Products and Services Received	Price
1	12-Week Candida Kit	*$1,014.00*
12	Weekly Evaluations to review progress	*$720.00*
12	Sessions of Exercise with Oxygen Therapy	*$600.00*
12	Sauna Treatments for detoxification	*$600.00*
12	Body Wraps for inch loss and detoxification	*$1,500.00*
12	Self-Mastery Technology (SMT)	*$600.00*
12	Sessions of Whole Body Vibration	*$600.00*
1	Follow Up Evaluation with Club Reduce Symptom Assessment	*$50.00*
	24 Hours a Day Phone Access to Club Reduce Staff	*Priceless!*
	Total Price for Everything	*$5,684.00*
	You Pay	

Your signature below indicates that you understand the following: All sales are final. You are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you, and you are personally responsible for payment. This office does not accept insurance of any kind. (Please advise us immediately if you are a Medicare patient, as we do not treat Medicare patients for services covered by Medicare.)

If you purchase this entire package, a discount may be given. You understanding that if the entire program isn't completed, the discount becomes void and the items and services rendered will be charged at the rates listed above.

If you move from the area before your program is completed, we will issue a store credit up to 3 months after the purchase date. The store credit will be good for any services not yet rendered that were scheduled to be performed after the date of your move. The amount of the store credit for those services will be given at the rate that was originally charged. If a discount was given, the credit will reflect that. All product sales are final and no refunds will be given, as you can and should continue to take the products.

When you are scheduled for a service or appointment, a room and employee are reserved for you. If you don't show up, the employee member and room assigned to you are not utilized, and resources are wasted. Therefore, if we do not have a 48-hour notice of cancellation for an appointment, you may still be charged for that service as if you had been here.

You authorize the staff to perform any necessary services needed during treatment.

You understand the above information and guarantee that this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information you have provided.

Your signature indicates that you understand these policies and that you will comply with the above requirements.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Date

_____ _____

Employee Signature Date

Checklist for Explaining Program

Date:_____ Person explaining program:_____
Patient:_____ Program:_____

INVENTORY
_____Complete product inventory with patient
_____Have patient sign product inventory
_____Have Wellness Coach sign product inventory
_____Emphasize to patient that the program includes ALL SUPPLEMENTS needed for the program. If the patient runs out because they use more than allotted or share them, they can purchase more from our clinic or online. They will NOT be given any more for free.

REFERRAL PROGRAM
_____Review Referral Program. This is a great way to get free product!!!
_____Give them Patient Referral Program Instructions (2 pages)
_____Give them 3 Patient Referral Cards

ONLINE REVIEW PROGRAM
_____Explain our online review program
_____Give them instruction form for online reviews

WEEKLY TREATMENTS/PROCEDURES
_____Give patient "Services" brochure
_____Explain each weekly visit procedure (they need to come to Wellness Coach before treatments)
_____Let them know what they need to wear
_____Let them know they MUST bring their food journal each week (NO EXCEPTIONS!)
_____Explain what they can expect on their first visit

NUTRITION PROGRAM
_____Review Food List
_____Calculate how much water they must drink each day
_____Review Structuring Your Diet
_____Review Detox
_____Review Healing Crisis
_____Review How to Take Your Supplements
_____Review Daily Food Log (food/supplement instructions and how to record food eaten)

CLUB REDUCE MEMBERSHIP SITE AND SOCIAL MEDIA
_____Give tour of Club Reduce membership site
_____Invite them to follow us on Facebook, Twitter, Pinterest, and our Blog
_____Invite them to the next class (cooking class, yoga class, etc.)
_____Invite them to the Monday support group

_____
EMPLOYEE SIGNATURE

Congratulations on Your Decision to Take Control of Your Health and Your Weight!

We have helped thousands of patients discover true health!

Typically, patients come to us to lose weight. What they don't realize is that although they will lose their weight, the most exciting part of the journey is the renewed energy and zest for life they discover.

We have found that most patients have spent years of unhealthy living in order to gain their weight and arrive at the condition they are in when they come to us for help.

Just as it took years of unhealthy living to gain your weight, it will take time to get healthy and arrive at your goal weight. But don't worry, you'll see some quick progress too!

Our goal is to be your lifetime partner in your quest to lose your weight, then maintain your weight and finally remain healthy!

This is a process that is a lot of work…yet EXTREMELY rewarding.

Even though you have signed up for a program with a beginning date and an ending date that is only for the first phase.

The first phase typically is to get you started on your weight loss journey. During this first phase, there are things you can expect from us and there are things we expect from you.

- Here are the 5 Things You Can Expect from Us:
    1. Detailed program guidelines to help you lose your weight
    2. Supplementation to help with dieter's nervousness and overall success
    3. Weekly visits to make sure you are on track
    4. Weekly phone calls in between visits to make sure you are on track
    5. Access to everyone on our staff that can assist you!

- Here are the 5 Things We Expect From You:
    1. Stick with all the program guidelines
    2. Record everything daily in your binder
    3. Show up for all your appointments
    4. Bring your binder with you to each visit
    5. Refer at least two patients to us every six months. (We have a message to spread!)

This is an exciting process. You will have ups and you may have downs. But we are here for you!

We are now your health partners for life, and we take this role very seriously!

Please communicate all of your concerns and needs to us. Our goal is to help you reach your goals!
Welcome to our Club Reduce Family!

_____	_____	_____	_____
Patient Signature	Date	Staff Signature	Date

Preferred Patient Referral Program

Each week in staff meeting we discuss our patients and how we can better serve them.

While all of our patients are important to us, some of our patients just make our work extra enjoyable!

You are one of those patients that we have singled out as "making our work extra enjoyable!"

We all look forward to your visits in our office, and quite frankly, we wish we had more patients JUST LIKE YOU!

Because of that, we have a "Preferred Patient Referral Program" implemented in our office called…

"We Want More Patients Like You!"

Here are some questions you might be asking:

What is Our Goal? To obtain more awesome patients that make our work enjoyable, like you do!

Why Would You Want to Participate? For every person that you refer that either attends one of our seminars or comes in for an evaluation, you'll receive one of the following:

- ☐ $25.00 coupon for products or services in our office
  Or
- ☐ Free Chocolate Nutritional Shake (or choose Strawberry, Orange or Vanilla)
  Or
- ☐ Free Body Wrap (Lose ½ dress size in one Wrap!)

Will This Be a Hassle for You to Participate in? No! Simply fill in the information on the back of this sheet with the names of the people that you think might be interested in some of our services. (You might not even be aware of all of the services we have available. Please see the back so you can see them all!)

Will We Be Bothering People You Refer? No! They will receive something in the mail…that's all! All we need from you is the name and mailing address for the people you'd like to refer. (If you don't have their address, we can search for it online.) We won't call, email or bother your friends. We'll simply send them something interesting in the mail. If they are interested, they'll respond; if they aren't, we won't be contacting them by any other means!

How Many People Can You Refer? We'd love all the referrals you'd like to give! We've had some patients that have referred so many that they've had lots and lots of credit in our office for products and services. That makes us happy, you happy and your referred friends happy!

How Will You Know If Your Referrals Come in? We make a point to find out where every patient comes from, so we can thank you and get your referral bonuses to you!

Your Name: _____

At Club Reduce, we have many programs available such as:

Breakthrough Weight Loss	*Diabetes/Blood Sugar Issues*	*Skin Care Programs*
Kids Weight Loss	*Candida*	*Body Wraps*
Teen Weight Loss	*Fibromyalgia*	*Saunas*
Family Weight Loss	*Pain Relief*	*Detoxification Programs*
Personal Training	*Hormone Balancing*	*Maintenance*

We would love to send out some literature on some of these programs to your friends, family, co-workers, or any other acquaintance you can think of who might benefit from this information. Please list people you know you might have an interest in any of this information. Please use an additional sheet if needed.

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

MEASUREMENT SHEET

Name: _____ Start Date: _____ End Date: _____

How many treatments are they receiving? _____ Expo/Groupon/Program_____

Area	Inches from Floor	Before	After	Difference
Arm – Right				
Arm – Left				
Rib Cage				
2" above umbilicus				
Umbilicus				
2" below umbilicus				
Hips				
Thigh – Right				
Thigh – Left				
Calf - Right				
Calf - Left				
Total Inches:				

NOTES: (BE SURE TO INCLUDE DATES AND INITIALS!)

Date:_____ BW or Lipo:_____ Number:_____ Tech Initials:_____ SMT:_____

Date:_____ BW or Lipo:_____ Number:_____ Tech Initials:_____ SMT:_____

Date:_____ BW or Lipo:_____ Number:_____ Tech Initials:_____ SMT:_____

Date:_____ BW or Lipo:_____ Number:_____ Tech Initials:_____ SMT:_____

Date:_____ BW or Lipo:_____ Number:_____ Tech Initials:_____ SMT:_____

Date:_____ BW or Lipo:_____ Number:_____ Tech Initials:_____ SMT:_____