
NEUROPATHY PROGRAM PROTOCOL

Patient Name: _____

✓ Products and Services Received

Weekly Evaluations

NeuroCare™ Sessions for pain relief

Leg Wraps for leg detoxification and circulation

Light Therapy for pain relief

Self-Mastery Technology Development tool

Whole Body Vibration

Follow up Evaluation at the completion of this program

times _____ for _____

_____ times _____ for _____

_____ times _____ for _____

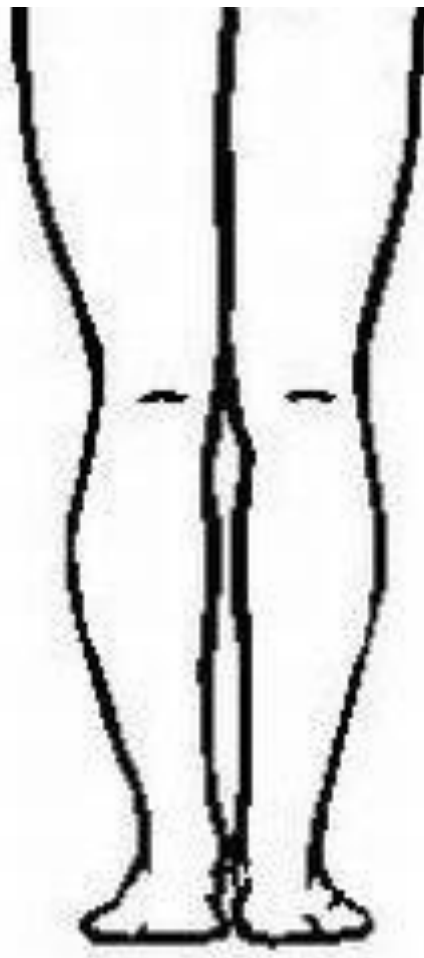
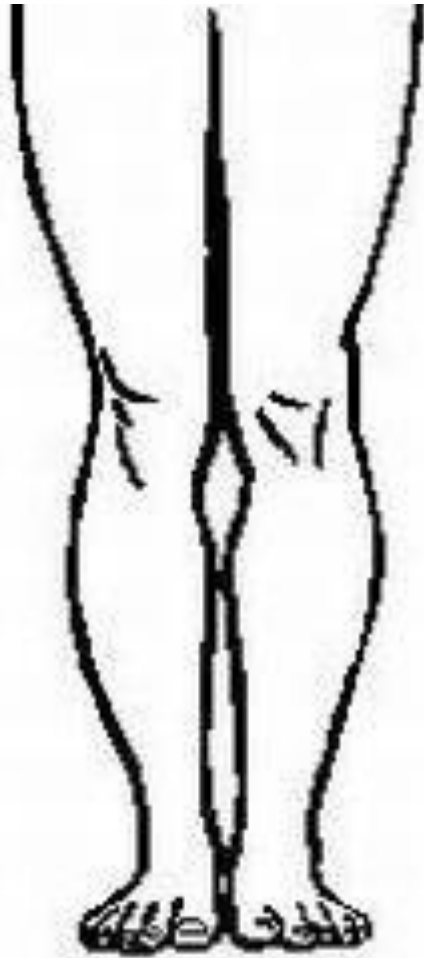
_____ times _____ for _____

_____ times _____ for _____

_____ times _____ for _____

Total Visits: _____

Areas being affected?



<i>Date and Visit Number</i>	<i>Services</i>	<i>Count of Services Received</i>	<i>Initials of who did treatment</i>
<i>Date:</i> ____/____/____ <i>Visit #</i> ____ <i>of</i> ____	<input type="checkbox"/> Evaluation	# ____ of ____	
	<input type="checkbox"/> NeuroCare™	# ____ of ____	
	<input type="checkbox"/> Light Therapy	# ____ of ____	
	<input type="checkbox"/> Leg Wrap	# ____ of ____	
	<input type="checkbox"/> SMT	# ____ of ____	
	<input type="checkbox"/> WBV	# ____ of ____	
<i>Date:</i> ____/____/____ <i>Visit #</i> ____ <i>of</i> ____	<input type="checkbox"/> Evaluation	# ____ of ____	
	<input type="checkbox"/> NeuroCare™	# ____ of ____	
	<input type="checkbox"/> Light Therapy	# ____ of ____	
	<input type="checkbox"/> Leg Wrap	# ____ of ____	
	<input type="checkbox"/> SMT	# ____ of ____	
	<input type="checkbox"/> WBV	# ____ of ____	
<i>Date:</i> ____/____/____ <i>Visit #</i> ____ <i>of</i> ____	<input type="checkbox"/> Evaluation	# ____ of ____	
	<input type="checkbox"/> NeuroCare™	# ____ of ____	
	<input type="checkbox"/> Light Therapy	# ____ of ____	
	<input type="checkbox"/> Leg Wrap	# ____ of ____	
	<input type="checkbox"/> SMT	# ____ of ____	
	<input type="checkbox"/> WBV	# ____ of ____	
<i>Date:</i> ____/____/____ <i>Visit #</i> ____ <i>of</i> ____	<input type="checkbox"/> Evaluation	# ____ of ____	
	<input type="checkbox"/> NeuroCare™	# ____ of ____	
	<input type="checkbox"/> Light Therapy	# ____ of ____	
	<input type="checkbox"/> Leg Wrap	# ____ of ____	
	<input type="checkbox"/> SMT	# ____ of ____	
	<input type="checkbox"/> WBV	# ____ of ____	
<i>Date:</i> ____/____/____ <i>Visit #</i> ____ <i>of</i> ____	<input type="checkbox"/> Evaluation	# ____ of ____	
	<input type="checkbox"/> NeuroCare™	# ____ of ____	
	<input type="checkbox"/> Light Therapy	# ____ of ____	
	<input type="checkbox"/> Leg Wrap	# ____ of ____	
	<input type="checkbox"/> SMT	# ____ of ____	
	<input type="checkbox"/> WBV	# ____ of ____	

*Staff must initial everything they complete.

NEUROPATHY PROGRAM EVALUATIONS

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

Visit #	Visit #	Visit #	Visit #
Date:	Date:	Date:	Date:
Pain Level:	Pain Level:	Pain Level:	Pain Level:
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:
NeuroCare™:	NeuroCare™:	NeuroCare™:	NeuroCare™:
Light Therapy:	Light Therapy:	Light Therapy:	Light Therapy:
Wrap:	Wrap:	Wrap:	Wrap:



SMT:	SMT:	SMT:	SMT:
Whole Body Vibration:	Whole Body Vibration:	Whole Body Vibration:	Whole Body Vibration:

Neuropathy Breakthrough Program © 2015 Club Reduce®

NEUROPATHY PROGRAM PRODUCTS

Patient Name: _____ Date: ____/____/____

✓	# of Units	Products Included in Program:	Price:
	1	Appetite Appeaser	\$24.00
	2	Body Purifier	\$46.00
	3	Cellulite Cleanse	\$72.00
	2	Cardio Health Essentials	\$60.00
	3	Digestive Enzyme	\$75.00
	1	Fiber Blend	\$25.00
	4	Salmon Oil	\$120.00
	2	Intestinal Cleanser	\$46.00
	2	Mixture Bottles (For the Lemonade Detox)	\$8.00
	1	Multivitamin/Mineral	\$32.00
	4	Nutritional Shake	\$208.00
	2	Vitamin D	\$30.00
	2	Probiotic Blend	\$56.00
	1	Exercise Gel	\$29.00
	1	Vitamin B12	\$15.00
		Total Price	\$846.00

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.

Signed
(Patient Signature)

Date

Signed
(Employee Signature)

Date

NEUROPATHY PROGRAM CONTRACT

✓ Products and Services Received	Price Per Session	Total
1 Supplement Kit	<i>\$846.00</i>	<i>\$846.00</i>
NeuroCare™ Sessions for pain relief	<i>\$50.00</i>	
Leg Wraps for leg detoxification and circulation	<i>\$50.00</i>	
Light Therapy for pain relief	<i>\$50.00</i>	
Self-Mastery Technology Development tool	<i>\$50.00</i>	
Whole Body Vibration	<i>\$50.00</i>	
Follow up Evaluation at the completion of this program	<i>\$50.00</i>	

Total Price for Everything

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

Date: _____ Person explaining program: _____

Patient: _____

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.

WEEKLY TREATMENTS/PROCEDURES

____ Explain each weekly visit procedure

____ Let them know they MUST bring their food journal each week (NO EXCEPTIONS!)

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

Checklist for Explaining a Neuropathy Program

____ 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

Notes

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!

Preferred Patient Referral Program

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 SMT Session

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 Lighthouse Health, we have many programs available such as:

Breakthrough Weight Loss

Kids Weight Loss

Teen Weight Loss

Family Weight Loss

Personal Training

Diabetes/Blood Sugar Issues

Candida

Fibromyalgia

Pain Relief

Hormone Balancing

Skin Care Programs

Body Wraps

Neuropathy

Detoxification Programs

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) _____