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 _____

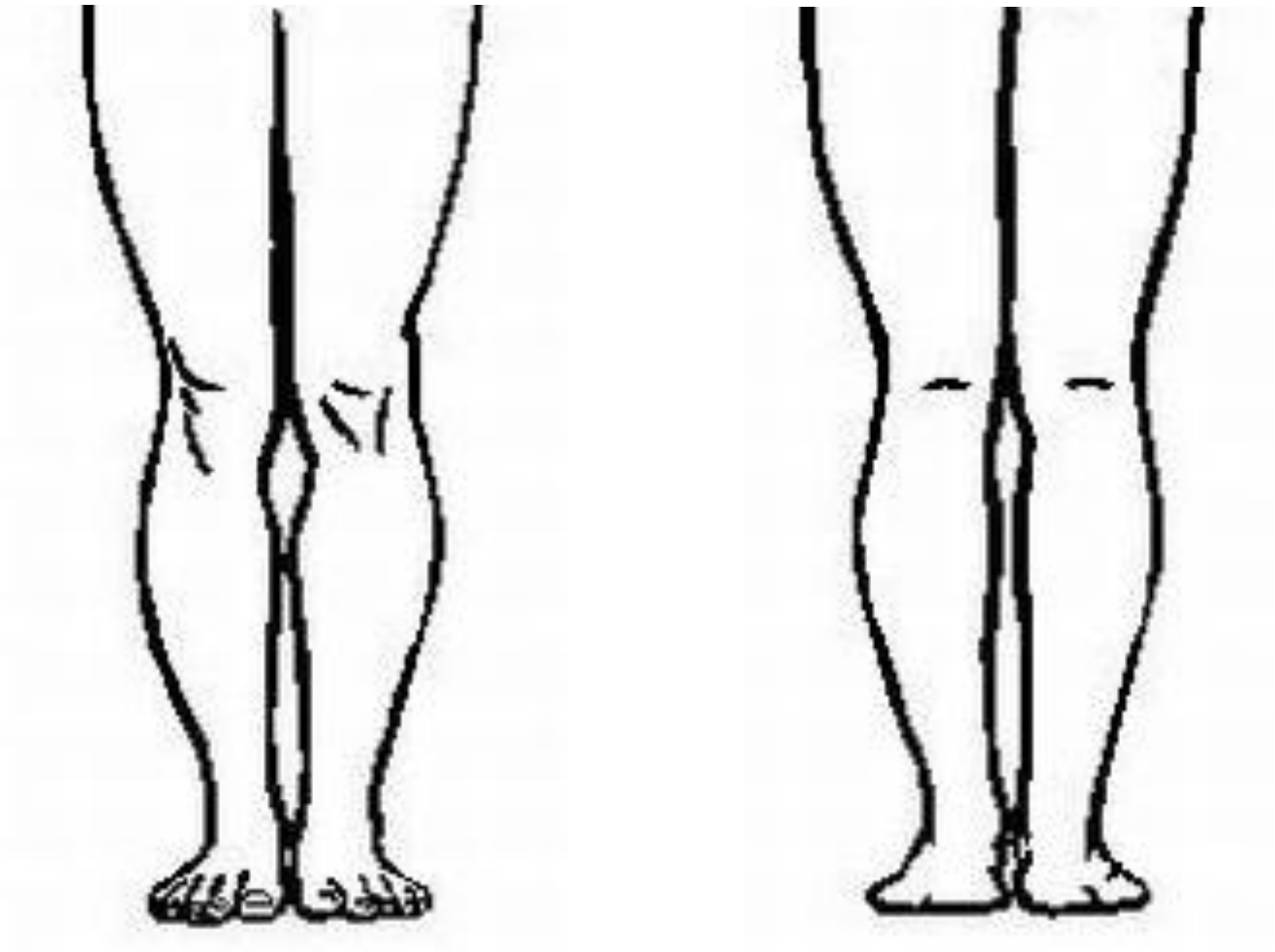
____ times _____ for _____

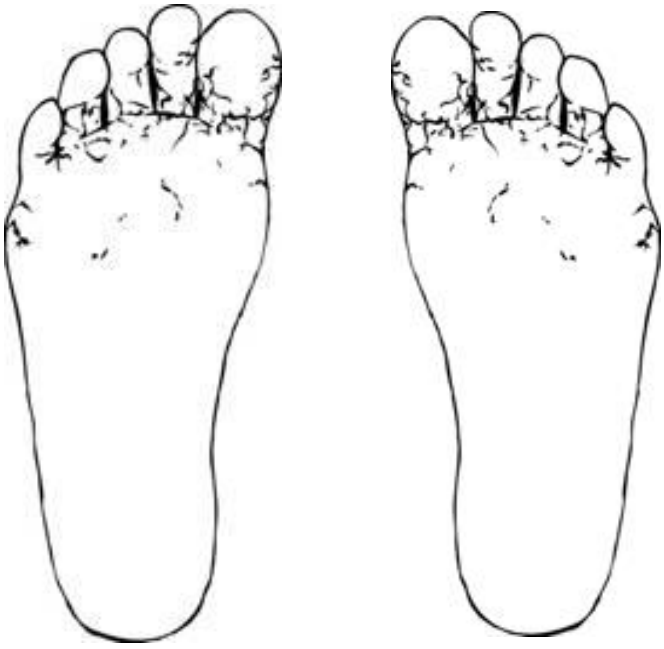
____ times _____ for _____

____ times _____ for _____

Total Visits: _____

Areas being affected?





NEUROPATHY PROGRAM PROTOCOL

Date and Visit Number	*Services*	*Count of Services Received*	*Initials of who did treatment*
	□ Evaluation	#____ of ____	
***Date:* ____ / ____ / ____**	□ NeuroCare™	#____ of ____	
	□ Light Therapy	#____ of ____	
	□ Leg Wrap	#____ of ____	
***Visit #* ____ *of* ____**	□ SMT	#____ of ____	
	□ WBV	#____ of ____	
	□ Evaluation	#____ of ____	
***Date:* ____ / ____ / ____**	□ NeuroCare™	#____ of ____	
	□ Light Therapy	#____ of ____	
	□ Leg Wrap	#____ of ____	
***Visit #* ____ *of* ____**	□ SMT	#____ of ____	
	□ WBV	#____ of ____	
	□ Evaluation	#____ of ____	
***Date:* ____ / ____ / ____**	□ NeuroCare™	#____ of ____	
	□ Light Therapy	#____ of ____	
	□ Leg Wrap	#____ of ____	
***Visit #* ____ *of* ____**	□ SMT	#____ of ____	
	□ WBV	#____ of ____	
	□ Evaluation	#____ of ____	
***Date:* ____ / ____ / ____**	□ NeuroCare™	#____ of ____	
	□ Light Therapy	#____ of ____	
	□ Leg Wrap	#____ of ____	
***Visit #* ____ *of* ____**	□ SMT	#____ of ____	
	□ WBV	#____ of ____	
	□ Evaluation	#____ of ____	
***Date:* ____ / ____ / ____**	□ NeuroCare™	#____ of ____	
	□ Light Therapy	#____ of ____	
	□ Leg Wrap	#____ of ____	
***Visit #* ____ *of* ____**	□ SMT	#____ of ____	
	□ 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:**

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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	$200.00
	2	Vitamin D	$30.00
	2	Probiotic Blend	$56.00
	1	Exercise Gel	$29.00
	1	Vitamin B12	$15.00
		Total Price	$838.00

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 Date
(Patient Signature)

_____ _____

Signed Date
(Employee Signature)

NEUROPATHY PROGRAM CONTRACT

✓	Products and Services Received	Price Per Session	Total
1	**Supplement Kit**	*$838.00*	*$838.00*
	NeuroCare™ Sessions for pain relief	*$50.00*	
	Leg Wraps for leg detoxification and circulation	*$50.00*	
	Light Therapy for pain relief	*$50.00*	
	Self-Mastery Technology Development tool	*$50.00*	
	Whole Body Vibration	*$50.00*	
	Follow up Evaluation at the completion of this program	*$50.00*	
	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

Checklist for Explaining a Neuropathy Program

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
_____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

_____

_____

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 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	*Diabetes/Blood Sugar Issues*	*Skin Care Programs*
Kids Weight Loss	*Candida*	*Body Wraps*
Teen Weight Loss	*Fibromyalgia*	*Neuropathy*
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) _____