

INSOMNIA SOLUTIONS PROGRAM PROTOCOL

PATIENT NAME:	DATE STARTED PROGRAM:
Initial Evaluation	☐ Double check all paperwork is filled out correctly
Date:	☐ Take Symptom Assessment
	☐ Close
	☐ Products given and explained
	☐ Daily Checklists explained
	☐ Contract and Product form signed by patient and employee
	☐ Referral program explained
	☐ Take "Before" Picture
	☐ Verify next scheduled visit
VISIT 1	☐ Evaluation to review journal and progress
Date:	☐ Exercise
	☐ Sauna
	☐ Body Wrap
	☐ SMT (During Body Wrap)
	☐ Verify next scheduled visit
VISIT 2	☐ SMT
Date:	☐ Verify next scheduled visit
VISIT 3	☐ Evaluation to review journal and progress
Date:	☐ Exercise
	☐ Sauna
	☐ Body Wrap
	☐ SMT (During Body Wrap)
	☐ Verify next scheduled visit
VISIT 4	☐ SMT
Date:	☐ Verify next scheduled visit
VISIT 5	☐ Evaluation to review journal and progress
Date:	☐ Exercise
	☐ Sauna
	☐ Body Wrap
	☐ SMT (During Body Wrap)
	☐ Verify next scheduled visit
VISIT 6	☐ SMT
Date:	☐ Verify next scheduled visit
VISIT 7	☐ Evaluation to review journal and progress
Date:	☐ Exercise
	☐ Sauna
	☐ Body Wrap
	☐ SMT (During Body Wrap)
	☐ Verify next scheduled visit
VISIT 8	☐ SMT
Date:	☐ Verify next scheduled visit
VISIT 9	☐ Follow up Symptom Assessment
Date:	☐ Evaluation to review journal, progress and to determine patients next steps
	☐ Exercise
	☐ Sauna
	☐ Body Wrap
	☐ SMT (During Body Wrap)
	☐ Ask for Testimonial / Take "After" Picture
	☐ Offer Maintenance Program
	☐ Schedule next evaluation a month out to review progress after program
VISIT 10	☐ SMT
Date:	☐ Verify next scheduled visit
VISIT 11	☐ Follow up Symptom Survey
Date:	☐ Evaluation to review progress and to determine patients next steps

*Staff must initial everything they complete.

INSOMNIA SOLUTIONS PROGRAM EVALUATIONS

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

Visit #		Visit #		Visit #		Visit #	
Date		Date		Date		Date	
Digestion		Digestion		Digestion		Digestion	
Elimination		Elimination		Elimination		Elimination	
Sleeping Habits		Sleeping Habits		Sleeping Habits		Sleeping Habits	
Energy Level		Energy Level		Energy Level		Energy Level	
Eval:		Eval:		Eval:		Eval:	
EWOT:		EWOT:		EWOT:		EWOT:	
SMT:		SMT:		SMT:		SMT:	
Sauna:		Sauna:		Sauna:		Sauna:	
Body Wrap:		Body Wrap:		Body Wrap:		Body Wrap:	

INSOMNIA SOLUTIONS PROGRAM

PRODUCTS

Patient Name: _____ Date: ____/____/____

✓	# of Units	<u>Products Included in Program:</u>	<u>Price:</u>
	1	Antioxidant	\$36.00
	1	Appetite Appeaser	\$24.00
	1	Body Purifier	\$23.00
	1	Detoxification Kit (Includes: Body Purifier, Fiber Blend, Intestinal Cleanser)	\$69.00
	2	Digestive Enzyme Blend	\$50.00
	1	Evening Primrose Oil	\$40.00
	1	Flax Seed Oil	\$30.00
	2	Fiber Blend	\$50.00
	1	Intestinal Cleanser	\$23.00
	1	Liquid Calcium	\$25.00
	1	Herbal Stress Relief	\$25.00
	2	Mixture Bottles (For the Lemonade Detox)	\$8.00
	1	Multivitamin / Multimineral	\$32.00
	2	Nutritional Shake (up to 3 scoops a day)	\$100.00
	2	Probiotic Blend	\$56.00
	1	Vitamin D	\$15.00
			Total Price
			\$606.00

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

INSOMNIA SOLUTIONS PROGRAM

CONTRACT

✓	Products and Services Received	Price	Quantity	Total Price
1	Better Sleep Supplement Kit	\$606.00	1	\$606.00
5	Weekly Evaluations and Weigh Ins	\$60.00	5	\$300.00
5	Sessions of Exercise with Oxygen Therapy	\$50.00	5	\$250.00
5	Sauna treatments for detoxification	\$50.00	5	\$250.00
5	Body Wraps	\$85.00	5	\$425.00
10	Self Mastery Technology (SMT) In-Office	\$30.00	10	\$300.00
1	Follow up Evaluation	\$50.00	1	\$50.00
	24 Hours a day phone access to the Doctor and Staff			Priceless!
Total Price for Everything				\$2,181.00
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 understand 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 on-line 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!)

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 (Yes, you could also 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 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
Saunas
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) _____