ChiroHealthUSA ChiroHealthUSAPLUS

DISCOUNT MEDICAL PLAN APPLICATION

THIS FORM SHOULD NOT BE GIVEN TO
PATIENTS UNLESS THEY ARE ENROLLING IN
CHIROHEALTHUSA OR CHIROHEALTHUSAPLUS

You must read important disclosures and sign the reverse side

Date: _____

Patient Name:

_____

Primary Card Holder Gender: ___Female ___Male

Primary Card Holder Date of Birth: _____

Dependents' Names: *(Spouse, Registered Domestic Partner, Dependent Children up to age 25, Parents in the Household over age 60, and any other IRS Dependent)*

_____

_____

_____

_____

Patient Address:

_____

City: _____

State: _____ **Zip:** _____

Phone:

_____

Email:

_____

(Contact information will not be shared, sold or distributed)

Payment information:

Choose One:

__ YES! I want ChiroHealthUSA **PLUS** for $89.00 for a **ONE YEAR** membership to include Chiropractic, Vision, Dental, Pharmacy, Lab and Imaging Discounts! **NOTE**: Not available in Vermont.

__ YES! I want ChiroHealthUSA for discounted Chiropractic Care Only for $ 49.00 for a **ONE YEAR** membership.

You may renew your agreement by continuing annual payments as applicable for your plan. The brochure for your program contains a description of the benefits you will receive and is incorporated by reference and is a part of this document. PLEASE READ YOUR BROCHURE BEFORE SIGNING THIS DOCUMENT.

Check #:_____

Credit card information will be destroyed once transactions completed.
Credit Card Type: Visa__ MC__ Amex__ Disc.__

Card#:_____ Card ID (CVV2/CID) Number: _____

Exp. Date: _____ Billing Zip Code: _____

Name on card: _____

Signature: _____

FOR CLINIC USE ONLY:
Provider Name: _____

Date entered in Online Membership Link: _____ By: _____

ChiroHealthUSA 1050 N. Flowood Dr., Suite C4, Flowood, MS 39232
1-888-719-9990 Fax: 1-888-685-2220
CHUSAAPP0711

CHUSA Processed _____ CHUSA+ Processed _____

Signature need on