DISCOUNT MEDICAL PLAN APPLICATION

ChiroHealthUSA®
The Network That Works for Chiropractic!

THIS FORM SHOULD NOT BE GIVEN TO PATIENTS UNLESS THEY ARE JOINING CHIROHEALTHUSA. You must read important disclosures and sign the reverse side

Date:

Patient Name:

Primary Card Holder Date of Birth:

Dependents' Names:
(Spouse, Domestic Partner, Dependent Children up to age 26, Parents in the Household over age 60, and any other IRS Dependent)

Patient Address:

City:

State: **Zip:**

Phone:

Email:

I understand email is an unsecured method of communication and I give my consent to email communications from ChiroHealthUSA.
You may opt-out of these communications at any time.
(Contact information will not be shared, sold or distributed) ◯ Yes ◯ No

FOR CLINIC USE ONLY
Date entered in Online Membership Link:
By:

◯ YES! I want ChiroHealthUSA for $49.00 for a ONE YEAR membership.

Not available in Washington state. 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. HSA and FSA accounts for payment of membership fees is not permissible.

DISCLOSURES

This discount medical plan is NOT insurance, a health insurance policy, or a qualified health plan under the Affordable Care Act. The plan only provides discounts on medical services and equipment offered by providers who have agreed to participate in the plan. The range of discounts for medical services and equipment offered under the plan will vary depending on the type of provider and medical services and equipment received. The plan does not make and is prohibited from making payments to providers for medical services or equipment received under the plan. The member is obligated to pay for all discounted medical services and equipment received under the plan, but will receive a discount on certain identified medical services and equipment from providers participating in the plan. The plan is subject to fees, requirements, and restrictions as specified in the membership agreement and includes a 30-day cancellation provision. Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00. Not available for sale in the state of Washington.

The Discount Medical Plan Organization/Discount Plan Organization is Perfectly Protected Practice, Inc. (d/b/a ChiroHealthUSA), 1307 Airport Rd. N, Suite 1A, Flowood, MS 39232, membership@chirohealthusa.com. You may call 1-888-719-9990 for more information and to request a list of program providers and the providers' city, state and specialty, located in your service area. You may also search for participating providers at ww.perfectlyprotectedpractice.com.

If you cancel within the first 30 days after the effective date, you are entitled to a refund of membership fees paid. If you cancel after the first 30 days, you are eligible for a pro-rata refund of membership fees paid. If we cancel your membership for any reason, other than non-payment, you are eligible for a pro-rata refund of membership fees paid. Refunds will be issued within 30 days of cancellation. You may cancel by contacting us at 1-888-719-9990 or membership@chirohealthusa.com or Perfectly Protected Practice, Inc., 1307 Airport Rd. N, Suite 1A, Flowood, MS 39232. Members receive at least 5% off usual and customary rates.

Signature:

Check and Credit card information will be destroyed once transaction is completed.

Check #:

Credit Card #: **CVV Number:** **Exp. Date:**

Billing Zip Code: **Name on Card:**

ChiroHealthUSA
1307 Airport Rd. N, Suite 1A, Flowood, MS 39232
1-888-719-9990

CHUSA PROCESSED ◯