# Wellness Programs for 2022 - 2023

March 1, 2022 through February 28, 2023

Wellness Plan Levels

We are happy to let you know how many minutes you have used this year and which level would be most economical for you next year. You can call the office or send us a message through OnPatient.

* Platinum Wellness Plan – for individuals or families (1-5 family members). 12 craniosacral therapy sessions or up to 525 minutes of care in a combination of CST’s and other visits. Annual payment $ 2300 or Monthly payment $192/month
* Gold Wellness Plan – for individuals or families (1-4 family members). 300 minutes of visits of care. Annual payment $1380 or Monthly payment $115/month
* Silver Wellness Plan – for individuals or families (1-2 family members). 150 minutes of visits of care /Annual payment $740 or Monthly payment $67/month
* Bronze Wellness Plan – for individuals only. 75 min of visits of care / Annual payment $390 or Monthly payment $37/month

Your level of Wellness Plan **cannot** be changed mid-way through the year. If you use all your WP minutes, you will be billed at a rate that is prorated according to your existing plan.

To renew an annual subscription for the 2022-23 Wellness Program:

* please sign the annual payment plan agreement form (attached) and send it back to us

To renew a monthly subscription

* please sign the monthly payment plan agreement form (attached) and send it back to us

# RENEWAL SIGN-UP FORM – Annual Payment Plan

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name) wish to subscribe to the 2022-2023 Wellness Program. I understand that this program begins on March 1, 2022 and ends on February 2023 and that any unused minutes do not roll over into the following plan year. *This program cannot be cancelled or refunded.*

(Choose one program)

* Platinum ❑ Gold ❑ Silver ❑ Bronze

(Choose one payment plan)

❑ Annual payment – I will sign up at [www.drzoe.com](http://www.drzoe.com)

* Annual payment – please invoice me for me to pay online
* Annual payment – please charge the card I have on file one week before the start of the program and send me a receipt. \*\* required \*\* last 4 digits of card you wish to have charged \_\_\_ \_\_\_ \_\_\_ \_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPOINTMENT CANCELLATION / NO SHOW POLICY**

Please give us 24 hours notice for appointment changes so other patients have access to that appointment time. If an appointment is cancelled with less than 24 hours notice, it will be considered a no show.

* Minutes will be deducted from the Wellness Program at a rate of 50% of the originally schedule appointment time for no shows (e.g., 15 minutes deducted for a 30 min appointment resulting in No Show)

**I have read and understand the Appointment Cancellation / No Show Policy and agree to its terms.**

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |   | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signature** |   | **Printed Name** |

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**