JUBILEE SPINE | FAMILY CARE PAYMENT AGREEMENT

Family Starter / Plus / Complete • Prepaid family care

Responsible party: _____ Date: _____

Phone: _____ Email: _____

1. PLAN SELECTION AND PAYMENT

Select	Plan	Prepaid amount	Discount on eligible visits
☐	Family Starter	$400.00	5%
☐	Family Plus	$750.00	10%
☐	Family Complete	$1,400.00	15%

The selected amount is paid once in advance and credited in full to a shared family balance. This is not a monthly membership, does not renew automatically, and does not guarantee a particular number of visits. No additional payment will be charged without separate authorization.

2. ELIGIBLE SERVICES AND PRICES

Service	Regular price	Starter (5%)	Plus (10%)	Complete (15%)
Adult focused visit (15 min)	$115.00	$109.25	$103.50	$97.75
Pediatric focused visit (under 18)	$85.00	$80.75	$76.50	$72.25

Pediatric pricing above is a proposed fee schedule and must be confirmed by Jubilee Spine before this agreement is used. Discounts apply only to the focused visits shown above while an eligible prepaid balance remains. New-patient evaluations, extended visits, products, diagnostic services, and insurance-billed services are excluded unless the Practice agrees otherwise in writing. Discounts cannot be combined with other offers.

3. AUTHORIZED FAMILY MEMBERS

The responsible party authorizes the following individuals to use the shared balance. Adding a member requires written approval. Payment authorization does not grant access to another adult's medical records.

Patient name	Relationship	Date of birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. FLEXIBLE USE AND CLINICAL CARE

Eligible services for any listed family member are deducted from the shared dollar balance as provided. Visits are scheduled according to each patient's clinical needs and availability; no visit frequency is required. Each patient has an individual clinical record. This financial agreement does not replace informed consent to treatment or a parent/guardian's consent for a minor.

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Terms, acknowledgments, and signatures

5. BALANCE, EXHAUSTION, AND RELOADING

The purchased balance does not expire due solely to inactivity. If the remaining balance is insufficient for a visit, the responsible party may pay the difference separately, subject to advance disclosure of the applicable rate, or choose not to receive that service. Reloading is optional and requires separate authorization. A new purchase may qualify for the tier selected at that time. The Practice will not retroactively change charges for services already delivered.

6. CANCELLATION AND REFUNDS

The responsible party may end participation at any time by written notice. Upon request, the Practice will refund the unused purchased balance, calculated as the amount paid less eligible services already provided at the agreed discounted prices and any other properly authorized charges. No cancellation or refund processing fee will be imposed. Refunds will be processed within 30 calendar days after an approved request, or sooner if required by law. Mandatory legal rights supersede these terms. Canceling this agreement does not automatically cancel scheduled appointments; the separately disclosed appointment cancellation policy may apply.

7. INSURANCE AND OTHER BILLING

This program is intended for eligible self-pay services only. It is not health insurance and does not guarantee insurer reimbursement. Medicare-covered and other insurance-billed services are excluded unless the Practice has independently confirmed that inclusion is lawful and consistent with applicable payer requirements. Any charges outside this agreement will be disclosed and billed separately in accordance with applicable law.

8. FEES, AVAILABILITY, AND CHANGES

The Practice may revise prices or program offerings prospectively with notice, but will not retroactively change charges for services already delivered. Any change affecting benefits associated with an existing prepaid balance is subject to this agreement and applicable law. Enrollment does not guarantee appointment availability, specific treatment results, or that any particular service is clinically appropriate.

9. ACKNOWLEDGMENTS AND AUTHORIZATION

By signing, I acknowledge that I understand the selected prepaid amount, discount tier, eligible services, exclusions, shared use of the balance, and refund terms. I authorize Jubilee Spine to apply charges for eligible services provided to the listed family members against this balance. I understand that this is a financial agreement only and does not substitute for clinical consent. I have had an opportunity to ask questions.

Responsible party signature: _____ Date: _____

Printed name: _____

Jubilee Spine representative: _____ Date: _____

OFFICE USE ONLY

Gift card / balance ID: _____ Amount received: $_____

Payment recorded in Jane: ☐ Yes ☐ No Authorized family members verified: ☐ Yes ☐ No

Important: Draft for review by a Virginia healthcare attorney before use. Confirm pediatric pricing, prepaid healthcare and gift-card rules, refunds, and Medicare/payer requirements.