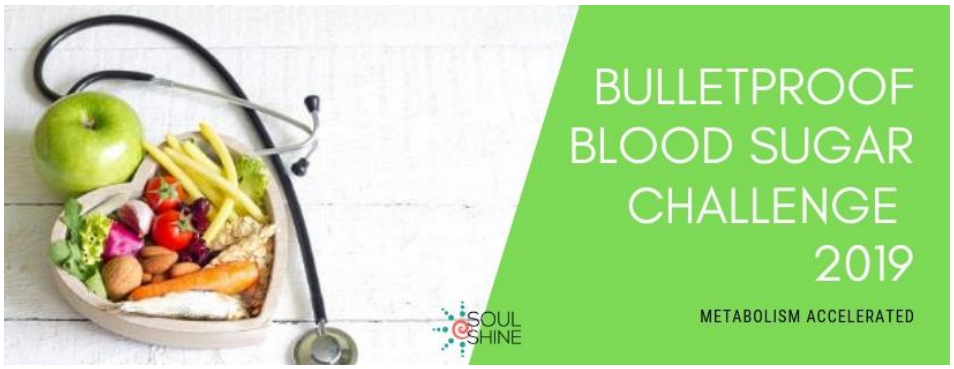

ENROLLMENT APPLICATION

Please complete the following information and return to Soul Shine Family Chiropractic in person or by emailing admin@soulshinechiro.com

First and Last Name: _____

Phone: (____) _____

Email Address: _____

How did you hear about the Challenge? _____

Payment Information:
Please circle one: VISA MC Amex

CC No.: _____

Exp. Date: _____ CVV: ____

I authorize my credit card to be billed for the amount indicated below:

Signature: _____

__6-week Challenge: $210
__Early-Bird (before Feb 20th): $189
__Have Equipment Y or N ? : -$65

_____ Staff Initials (office use only)

SOUL SHINE FAMILY CHIROPRACTIC
440 S E St. Santa Rosa, 95404
T: (707) 525-9950 / F: (707) 525-9230
Email: admin@soulshinechiro.com