

**ALLIED MEDICAL CENTER
Medical Membership Program
Enrollment Form**

PAYMENTS TO BEGIN: /__ / 1ST or /__ / 15TH

TYPE OF ID VERIFICATION:

DATE: ____ / ____ / ____

EMPLOYEE or INDIVIDUAL INFORMATION

EMPLOYEE or INDIVIDUAL: _____ / _____ / _____ GENDER
Last First Middle Initial M F

DATE OF BIRTH: ____ / ____ / ____ PHONE #: (____) _____ EMAIL: _____
MM DD YRR

STREET ADDRESS: _____
City State Zip

FAMILY (to be included in membership) INFORMATION

SPOUSE: _____ DATE OF BIRTH: ____ / ____ / ____ GENDER
M F

CHILD #1: _____ DATE OF BIRTH: ____ / ____ / ____ M F

CHILD #2: _____ DATE OF BIRTH: ____ / ____ / ____ M F

CHILD #3: _____ DATE OF BIRTH: ____ / ____ / ____ M F

CHILD #4: _____ DATE OF BIRTH: ____ / ____ / ____ M F

PAYMENT OPTIONS (circle one) BILLING BANK DRAFT CHECK CREDIT CARD MONEY ORDER CASH

HOW MANY PAYMENTS (circle one) 1 2 3 4 NOTE: There is a five dollar (\$5) Processing Fee for EACH installment payment.
 There is a one- time Set Up Fee of twenty-five dollars (\$25).

PLEASE INDICATE THE NUMBER OF PEOPLE INCLUDED IN THIS PLAN : _____

TOTAL AMT. DUE: \$ _____ (+) \$25.00 (+) \$5.00 per payment = GRAND TOTAL: \$ _____

I authorize Discount Medical, ALLIED MEDICAL CENTERS, P LLC to initiate Debits and/or Credits to my checking account at the Depository Financial institution "BANK" as indicated by the Transit Routing Number that I have supplied on this form, and BANK is to pay such Debit or Credit. This authorization is to remain in full force and effect until Discount Medical, ALLIED MEDICAL CENTERS, P LLC or BANK has received written notification from me of its termination in such time and in such manner as to afford Discount Medical, ALLIED MEDICAL CENTERS, P LLC or BANK a reasonable opportunity to act on it.

NOTE: If using checking account, please attach a "VOIDED" check with this application.

NAME OF BANK/FINANCIAL INSTITUTION: _____ CHECKING ACCOUNT #: _____

BANK/INSTITUTION ADDRESS: (City) _____ (State) _____ (Zip) _____

TRANSIT/ROUTING #: _____ ACCOUNT HOLDER SIGNATURE: X _____

I wish to pay by credit card until I revoke this authorization IN WRITING. (Circle One): VISA/MASTERCARD DISCOVER CARD DEBIT CARD

NAME AS IT APPEARS ON CARD: (please print) _____

CARD #: _____ EXP. DATE: ____ / ____ CVC #: _____
MM YR

SIGNATURE OF CARD HOLDER: _____

BILLING INFO IF DIFFERENT FROM MEMBER: Name: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____