Add / Remove Family Members

PERSONAL MD®

PRIMARY MEMBER INFORMATION		
Last Name:	First Name:	DOB
Billing Address	City:	State: TX Zip:
Phone #1: ( ) __ Work __ Cell ___ Home	Phone #2: ( ) __ Work __ Cell __ Home	

MEMBERSHIP INFORMATION	
DATE:	Company:

Add a mebmer to my contract

ADDITIONAL MEMBERS: PRICE LIST Adult: $80/month | Child $40/month | Family max $250/month

Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:

Remove a member from my contract

Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:

AUTHORIZATION

- By signing below, I hereby authorize Personal MD to contact me using the information I have provided above. By signing below, I hereby authorize Personal MD to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account. (Example: No show fees).
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Personal MD has received written notification from me of its termination in such time and in such manner as to afford Personal MD and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in Personal MD is continuous and that, by signing below, I authorize recurring credit/debit card charges.
- I understand and that a $25 fee will be charged to me for declined credit card, debit card, or bank account transaction(s) that are not honored.

By signing below, I acknowledge that I am authroized to make changes to your contract.

A photocopy or scanned copy of the above information is to be considered an original. I understand that I am financially responsible for all charges accumulated from visits to Personal MD Family Healthcare, P.A. (Personal MD) I understand that Personal MD does not accept any insurance of any kind and will not file to your insurance carrier after your visit to Personal MD. I also understand that being seen in our office for medical care is consent to receive treatment. I hereby authorize the physician to treat myself or if a minor, my child, as deemed medically necessary.

SIGNATURE OF GUARANTOR/ACCOUNT HOLDER	
Date:	
Print Name:	Signature: