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| **Member Enrollment** |  |

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| MEMBER INFORMATION | | | | | | | | | | | |
| Last Name: | | | | | First: | | | | | | Middle: |
| Birth Date:  MM /DD/YYYY | | | /    / | | | | | | Gender:  Male  Female | | |
| Home Address: | | | | | | | | | | | |
| City:      State:      Zip: | | | | | | | | | | | |
| Phone: (     )     −      Home  Cell | | | | | | Phone: (     )     −       Home  Cell | | | | | |
| Email address: | | | | | | | | | | | |
| Agreements | | | | | | | | | | | |
| I have received a copy of the Retainer Medical Agreement/Direct Primary Care Agreement | | | | | | | | | | | |
| Enroll Spouse/Dependent | | | | | | | | | | | |
| Last Name: | | | | First: | | | | | | Middle: | |
| Birth Date:  MM/DD/YYY | | | /    / | | | | Gender:  Male  Female | | | | |
| Phone: (     )     −       Home Cell | | | | | | | | Phone: (     )     −       Home  Cell | | | |
| Email address: | | | | | | | | | | | |
| Enroll Additional Members in Household | | | | | | | | | | | |
| **Dependent** | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | | | | | | | | | | |
| **Dependent** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | | | | | | | | | | | |
| **Dependent** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | | | | | | | | | | | |

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| **Emergency Contact** | | | |
| Name: | Relationship  to patient: |  | Phone: (     )     − |
| Name: | Relationship  to patient : |  | Phone: (     )     − |

**Membership Billing Information**

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| Billing Information |

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| Payment Schedule: | Monthly  Quarterly  Annual | | | **Enrollment fee of $85.00 per houshold** *(one-time fee with no lapse in membership, non refundable, rejoining fee if lapsed $185.00)* |
| **Monthly Pricing:** | 1  *or* 2  Individual age 19 - 65 $75.00  1  *or* 2  Individual age 66 + $86.00  Independent Youth $55.00  *(age 18 - 26)* | | | 1 Adult, 1 child *(under age 26)* $91.00  Family 2 Adults, $172.00  *(up to 2 child thru age 25)*         Additional child $18.00 each  *(enter number)* |
| Desired Payment Date: | | 1st  5th | **Payment Method (choose one**)  Credit or Debit Card  Bank Account  *Discount available* | |

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| Card type:  CC **or**  HAS/FSA  *(all cards accepted)* | |  | Bank Account Information | |
| Cardholder’s name: | |  | Account holders name: | |
| Card number: | |  | Bank name: | |
| Expiration Date: MM/YYYY | / |  | Account number: | |
| Security Code: | |  | Routing number: | |
| **Authorization Statement:** I authorize Nicc’s Direct Primary Care, to charge my credit card, debit card, HSA/FSA card or bank account for an $85.00 one-time enrollment fee and on a recurring basis for my Retainer Medical Agreement/ Direct Primary Care Membership per the above selected frequency until I have cancelled my membership 30 days in advance, in writing. If my credit card company or bank delince charges my membership is cancelled immedicately until I make another payment and may be subject to a re-enrollment fee. I also agree to pay a $25.00 NSF for any returned payment. If I or by bank reverse my credit/debit card payment I agree to pay a $35.00 cancellation fee and all other fees associated with the original payment and the reversal of payment. Further I acknowledge a reversal of payment may cause my account to be sent to collections.  I understand that insurance will not be billed for services covered under my membership. | | http://kwc.edu/_uploads/sites/2/Check-Example.gif | | |
| Authorization Signature: | | | | Date:    /    / |

Email completed form: [admin@niccdpc.com](mailto:admin@niccdpc.com) Or mail: 4509 S. 6th Street, Suite 301 / Klamath Falls OR 97603

*Membership Start date:    /    /*