Enrollment Form

NICC'S DPC

Membership Start date: / /

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 Dependents in Household

Last Name: First: Middle:

Birth Date: MM/DD/YYYY / / Gender: ☐ Male ☐ Female

Alternate phone (if different than above): ( ) – ☐ Home ☐ Cell

Email address:

Last Name: First: Middle:

Birth Date: MM/DD/YYYY / / Gender: ☐ Male ☐ Female

Alternate phone (if different than above): ( ) – ☐ Home ☐ Cell

Email address:

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

Billing Information

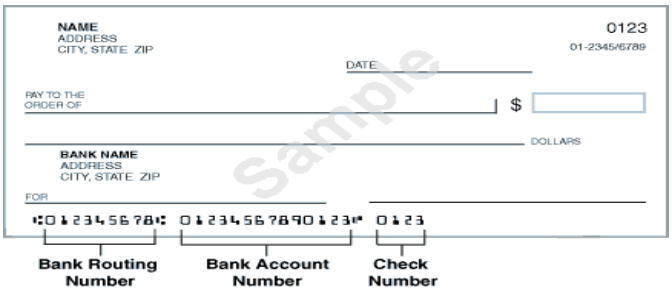
Payment Schedule:	☐ Monthly ☐ Quarterly ☐ Annual	**Enrollment fee of $100.00 per houshold** *(one-time fee with no lapse in membership, non refundable, rejoining fee if lapsed $215..00)*
Monthly Pricing:	1 ☐ *or* 2 ☐ Individual age 19 - 65 $75.00 1 ☐ *or* 2 ☐ Individual age 66 + $86.00 ☐ Independent 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

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 $100.00 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.



Authorization Signature:	Date: / /

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