Member Enrollment

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:

Continued on next page

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 $85.00 per houshold** *(one-time fee with no lapse in membership, non refundable.)*
Monthly Pricing:	1 ☐ or 2 ☐ Individual age 26 - 65 $69.00 1 ☐ or 2 ☐ Individual age 66 + $79.00 ☐ Independent youth $50.00 *(age 18 -25, individual membership)*	☐ 1 Adult, 1 child *(under age 26)* $84.00 ☐ Family 2 Adults, $158.00 *(up to 2 child thru age 25)* _____ Additional child $15.00 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)*	<u>Bank Account Information</u>
Cardholder's name:	Account holders name:
Card number:	Bank name:
Expiration Date: MM/YYYY /	Account number:
Security Code:	Routing number:

☐ Authorization Sttement: 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 non-frefundable 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 in writing with 30 days notice. 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.

☐ 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

Membership Start date: / /