MEMBERSHIP ENROLLMENT

SELECT A PLAN ☐ Prestige HD ☐ Prestige VIP ☐ Prestige Pediatric

ADULT ENROLLMENT

PATIENT 01 *(This individual is the main account holder and is responsible for patients associated with this account)*

Last Name _____ First Name _____ MI _____

Gender ☐ M ☐ F Date of Birth _____ Driver's License No. _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____
(if different from Home Address)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

Emergency Contact: Name _____ Phone Number _____ Relationship to Patient _____

PATIENT 02

Last Name _____ First Name _____ MI _____

Gender ☐ M ☐ F Date of Birth _____ Driver's License No. _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____
(if different from Home Address)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

Emergency Contact: Name _____ Phone Number _____ Relationship to Patient _____

PATIENT SERVICES AGREEMENT

I hereby certify that I have read and agree to the terms and conditions specified in the Patient Services Agreement.

Patient Signature _____ Date _____

MEMBERSHIP ENROLLMENT

CHILD ENROLLMENT

CHILD 01

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

Emergency Contact: Name _____ Phone Number _____ Relationship to Patient _____
(for all children)

CHILD 02

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

CHILD 03

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

CHILD 04

Last Name _____ First Name _____ MI ____ Gender ☐ M ☐ F Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____
(if different from Adult #1)

☐ *Home* ☐ *Work* ☐ *Cell* ☐ *Home* ☐ *Work* ☐ *Cell*

Email Address _____ Phone #1 _____ Phone #2 _____

MEMBERSHIP ENROLLMENT

A NEW AND REFRESHING HEALTHCARE EXPERIENCE

Prestige Urgent Care does not require a long-term contract or commitment. You may cancel your membership at any time. Three easy payment options are available:

- **Month to Month Membership** - Members pay membership fees monthly via drafts against a credit card, debit card, bank account, or suitable alternative.
- **Six-Month Prepaid Membership** - Members pay for a six month membership in advance and receive a 5% discount.
- **Full Year Prepaid Membership** - Members pay for a full year membership in advance and receive a 10% discount.

Enrollment Fee – One time fee of $59 for initial enrollment.

BILLING INFORMATION

Name _____ Phone Number _____ Email _____
(as it appears on your credit card or bank account)

Billing Address _____ City _____ State _____ Zip Code _____

MONTHLY PAYMENT INFORMATION

Please indicate the method to pay monthly membership fees or prepay. Payment information also can be provided in person at our clinic or over the phone.

- My first month's payment is $ _____
  (enter amount, including enrollment fee if applicable),
- My subsequent monthly payments will be $ _____
  (enter monthly amount or zero if 6 or 12 month prepay).

CREDIT CARD INFORMATION

We accept Visa, Mastercard, Discover and American Express.
For Bank Account withdrawals, please provide a voided check.

CREDIT OR DEBIT
Card Type _____ Card Number _____ Security Code _____ Exp. Date _____ Name on Card _____
(last four digits)

BANK ACCOUNT
Bank Name _____ Account Number _____ Routing Number _____ Name on Account _____

OTHER
Please Specify _____

I hereby authorize Prestige Urgent Care to deduct my monthly membership fee from the payment source listed above:

Patient Signature _____ Date _____