REGISTRATION — PATIENT INFORMATION

First Name: **Last Name:** MI: DOB: ☐ Male ☐ Female

Home address: City: State: ZIP:

Billing address: ☐Same as home City: State: ZIP:

Phone #1: ( ) ☐Home ☐Work ☐Cell Phone #2: ( ) ☐Home ☐Work ☐Cell

Email Address:

Emergency Contact: Phone: ( ) Relationship:

ADDITIONAL FAMILY MEMBERS ON MY ACCOUNT

First Name: **Last Name:** ☐Same as mine MI: DOB: ☐Under 26 ☐Male ☐Female

Phone #: ( ) Email Address: Relationship to Me:

First Name: **Last Name:** ☐Same as mine MI: DOB: ☐Under 26 ☐Male ☐Female

Phone #: ( ) Email Address: Relationship to Me:

First Name: **Last Name:** ☐Same as mine MI: DOB: ☐Under 26 ☐Male ☐Female

Phone #: ( ) Email Address: Relationship to Me:

First Name: **Last Name:** ☐Same as mine MI: DOB: ☐Under 26 ☐Male ☐Female

Phone #: ( ) Email Address: Relationship to Me:

First Name: **Last Name:** ☐Same as mine MI: DOB: ☐Under 26 ☐Male ☐Female

Phone #: ( ) Email Address: Relationship to Me:

First Name: **Last Name:** ☐Same as mine MI: DOB: ☐Under 26 ☐Male ☐Female

Phone #: ( ) Email Address: Relationship to Me:

BILLING

BILLING IS RECURRING AUTOMATICALLY ON A MONTHLY BASIS

Credit or Debit Card #: Expiration: 3 Digit Security #:

Card billing address: ☐Same as home City: State: ZIP:

☐ *Please add me to the billing account of an existing Appleton Clinics patient associated with the above credit card:*

Email Address:

AUTHORIZATION

On behalf of all of the members on this account, I understand and agree to the following (read and initial all items indicating your acceptance):

____ A one-time $99 registration fee per adult member will be included in my total initial charges

____ I will be charged a $99 monthly recurring fee per adult member for primary care services as described at AppletonClinics.com. If I elect to pre-pay annually I will receive a two-month discount per year ($198)

____ No service fees are charged for the first two children under 26 years old, with at least one paid adult family member. I will pay a $10 monthly recurring fee for each additional child.

____ I may cancel at any time, but no refunds will be issued for paid fees.

____ If my membership lapses I may re-apply at any time subject to a $99 re-registration fee; acceptance will be dependent upon availability of clinic space

____ I will pay a $25 fee for declined credit or debit card transactions

____ Prescriptions, certain vaccinations, medical supplies and other items provided but not covered by my monthly primary care service fee will be discussed with me in advance and automatically charged to my account's credit/debit card at the time such items are provided to me.

____ The transaction amounts charged will include my fees plus the fees incurred by all individuals listed above.

____ My participation is continuous and by signing below I authorize recurring credit/debit card charges.

____ My participation is voluntary and subject to the terms and conditions of membership detailed at AppletonClinics.com

____ I understand **this agreement does not include comprehensive health insurance coverage nor is it a contract of insurance**.

____ I understand specialty care, hospitalizations, surgery, third-party medical treatments and other medical products and services not specifically provided by Appleton Clinics are my sole responsibility and are not included or paid for by Appleton Clinics.

SIGNATURE:______________________________ DATE______________

PRINT NAME:______________________________ SIGNATURE BY: ☐PATIENT ☐ PARENT ☐LEGAL GUARDIAN

Mail / drop off completed form to: Appleton Clinics • 607 25 Road, Suite 201, Grand Junction, CO 81505

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