THE FAMILY DOCTOR
Est. 2014
PRIMARY CARE & TRAVEL MEDICINE

PAYMENT AUTHORIZATION

	Monthly	Quarterly	Semi-Annual	Annually
Age 0-18 years (with paying adult)	**___ x $15**	**___ x $45**	**___ x $85**	**___ x $160**
Age 0-18 years (without paying adult)	**___ x $40**	**___ x $115**	**___ x $230**	**___ x $435**
Age 19-64	**___ x $100**	**___ x $285**	**___ x $560**	**___ x $1080**
Age 65+	**___ x $125**	**___ x $355**	**___ x $700**	**___ x $1350**
Total	**$_____**	**$_____**	**$_____**	**$_____**

Individuals covered:

_____ _____

_____ _____

_____ _____

Debit/Credit Card ***OR*** ***Electronic withdrawal from bank account***

☐ VISA

☐ Mastercard

☐ Discover

☐ American Express

Last 4 Digits of Card: _____

Zip Code of Card: _____

☐ Checking

☐ Savings

Bank Name: _____

Bank City & State: _____

Bank Routing Number: _____

Bank Account Number: _____

Initial

____ I authorize The Family Doctor, PLLC to use this payment method to charge for all labs, medications, recurring payments, and other expenses related to health-care delivery.
____ I understand that there is a one-time enrollment fee for new patients.
____ I authorize receipts to be emailed to my email address on file.
____ I understand that the prices will automatically adjust up to the next payment tier as patients age.
____ I understand that this form is valid unless I cancel through written notice to The Family Doctor, PLLC.

Account Holder Name: _____

Account Holder Signature: _____ Date: _____