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
Medicare Part B Only	___ x $100	___ x $285	___ x $560	___ x $1080
Total	$_________	$_________	$_________	$_________

Individuals covered:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Debit/Credit Card

☐ VISA

☐ Mastercard

☐ Discover

☐ American Express

Last 4 Digits of Card: __________

Zip Code of Card: _____________

OR

Electronic withdrawal from bank account

☐ 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: _________