**Patient Information:**

Rev. 08/20

AFFIX PT LABEL HERE

**Patient SSN:** \_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

**Emergency Contact:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number Relation

**Insurance:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number / Policy Number

**Automatic Payment:**

Your monthly payment will automatically be deducted from your account. Payments will be made directly through our secure link, which can be accessed through the electronic statement sent to your e-mail. Your statement will include the monthly fee plus incidental charges (such as lab fees, medications, and other non-included charges). I authorize Pine Ridge Family Medicine to automatically bill my monthly membership fee, plus any incidental charges to the card listed below as specified:

**Credit Card:** Ending in –\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_/\_\_\_\_\_\_\_

Amount: $\_\_\_\_\_\_\_\_ to be deducted on the **1st  5th 10th  15th 20th 25th**  of the month.

*\*Autocharge date is the option above immediately prior to enrollment date.*

By signing below, I agree to pay the contracted monthly amount by the same day of each month by cash, check, card, or automatic withdrawal. Any additional incidental charges will be collected at the time of service or with the following monthly payment. I certify that I understand the terms and conditions of this PRFM Agreement form. *This contract can be cancelled at any time with a 30-day notification. Prices are subject to change with 90-day notice.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / / \_\_\_

**Patient Signature Date**

*I understand that if I choose* ***not*** *to have a credit/debit card on file, I will be responsible for paying all incidental charges (such as lab fees, immunizations, x-rays, prescriptions, and other non-included charges) at the time of service. Monthly fee will be due by the 1st of the month.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date