PATIENT ENROLLMENT AGREEMENT

Monthly membership fee shall apply to the following patient(s), who by signing below; agree to the terms and conditions of the PRFM Agreement form.

_____ _____ _____ M / F
Printed Name Date of Birth Age Gender

_____ _____
Street Address City, State, Zip Code

_____ _____ _____ _____
☐ Home Phone ☐ Cell Phone ☐ Work Phone E-mail Address
Please check box next to you preferred contact number.

_____ _____ _____ M / F
Spouse's Name Date of Birth Age Gender

_____ _____ _____ _____
☐ Home Phone ☐ Cell Phone ☐ Work Phone E-mail Address
Please check box next to you preferred contact number.

Emergency Contact_____ Phone_____

Child/Children to Whom this Agreement Applies:

_____ _____ _____ M / F
Printed Name Date of Birth Age Gender

_____ _____ _____ M / F
Printed Name Date of Birth Age Gender

_____ _____ _____ M / F
Printed Name Date of Birth Age Gender

_____ _____ _____ M / F
Printed Name Date of Birth Age Gender

_____ _____ _____ M / F
Printed Name Date of Birth Age Gender

I certify that I agree to pay the contracted monthly amount by the same day of each month by cash, check or automatic withdrawal from my credit or debit card. Any additional incidental charges will be collected at the time of service or on the following month. This contract can be cancelled at any time with a 30-day written notification. Prices are subject to change with 90-day notice.

_____ _____ _____ _____
Patient Signature Date Spouse Signature Date

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