PATIENT ENROLLMENT AGREEMENT

Patient Demographics:

_____ _____ _____ M / F
Patient Name **Date of Birth** **Age** **Gender**

_____ _____
Street Address **City, State, Zip Code**

_____ _____ _____
☐ **Cell Phone** ☐ **Other:**_____ **E-mail Address**
Please check box next to preferred contact number.

_____ _____ _____
Insurance Company **Group Number** **Policy Number**

_____ _____ _____
Emergency Contact **Phone Number** **Relation**

Additional Patient(s):

Spouse/Significant Other:

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

_____ _____ _____
☐ Cell Phone ☐ Other: _____ E-mail Address

Child/Children:

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

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

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

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

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

By signing below, I agree to pay the contracted monthly amount for all listed members 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 the PRFM Agreement form. *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** Patient Signature Date

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