GRANTS PASS FAMILY MEDICINE PC

Name of Business: _____

Business Contact: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

E-mail address: _____

Employee Members: Attach Employee Registration forms for each employee and family member. Attachment A will list all members and dates of birth to enroll. The monthly fee for each employee listed is $55. If the Business is also providing this benefit to their employee's spouse and children, the monthly fee for each spouse listed is $55 and for each child (under 20) is $15.

Payment by check, automatic bank withdrawal (ACH), or Visa/MasterCard, to include the first month's membership fee for all listed employee Members, is due with your employees' enrollment forms, along with your authorization for ongoing automatic monthly payments and your acknowledgement of the Employer Terms and Conditions. Please make checks payable to: Grants Pass Family Medicine, PC.

• Monthly membership fees will be transferred to Grants Pass Family Medicine, PC on a monthly basis as payment for the subsequent month's charges. The first and subsequent payments typically come out on the day of the month that the employer provides all of the completed employer and employee forms to Grants Pass Family Medicine. If you desire a different payment date each month please notify us at the time of turning in all forms.

• I understand that this Authorization will remain in effect until Grants Pass Family Medicine, PC has received written notice from me of cancellation. Membership is month to month. I have the right to stop payment of a specific transfer at least three (3) business days before the next scheduled payment.

• I understand and authorize that a $25 fee will be charged to me for non-sufficient funds or any event preventing payment to Grants Pass Family Medicine, PC

• I understand that the standard recurring transaction amount is the total of all the monthly membership fees for all the employee (and family if applicable) Members named on my account as listed on Attachment A to this authorization.

• I understand that I shall notify Grants Pass Family Medicine, PC of any changes in my account information or of the Members listed on my account in accordance with the provisions of the Employer Terms and Conditions.

Authorization for automatic payment of recurring monthly fee:

# of Adults ___ X $55/mn: $_____ # of Children (under 20) ___ X $15/mn: $____ **Total monthly fee**: $_____

% of lab fees employer pays _____(optional) % of medication fees_____ (optional)

O Credit or Debit Card:

Name on Card: _____ Card Billing Address: _____

Card Type: O Visa O MasterCard Expiration Date: _____ _____

Card Number: _____ 3 Digit Security Code (on back of card): _____

OR

O Banking Account: Voided check attached.

Bank: _____ Name on Account: _____

Routing Number: _____ Account Number: _____

I understand and will comply with the above payment terms. I hereby authorize Grants Pass Family Medicine, PC to initiate credit/debit card transactions or automatic bank withdrawals on a monthly basis for the above total monthly fee. I authorize my financial institution to honor these transfers. I understand I may revoke this authorization with written direction at any time.

Signature: _____ Date: _____

Title: