THE PRACTICE

I hereby authorize “The Practice” to debit my checking account or credit card as agreed upon monthly for the services provided by “The Practice.

I fully understand that it is my responsibility to provide and maintain the most up to date records of my current financial institute, bank account information and any other financial information that would affect my monthly payments.

I understand that by signing this form I am signing up for “The Practice” for a 1 year contract then to continue to be month to month till canceled by patient. I also understand that I cannot break this contract without owing the full 1 year payments. If I wish to cancel this service I am aware that I will need to call and give a 2 week notice for the payments to be stopped after the 1 year period.

Please Circle the Plan of your choice

Tier 1- Practice $69.00 per Person

Tier 2- Practice $99.00 per Person

Add- Family Pharmacy for Only an additional $44 per person

Name on Card_____Billing Zip_____

Credit Card #_____Credit Card Code_____

Exp. Date_____Date of monthly debit _____

_____

Signature Date