directcareMD

Payment Authorization

P.O. Box 89, Chehalis, WA 98532
Phone 360-740-0888 Fax 360-740-0555

Primary Member Name: _____

Address: _____

_____
City State Zip

Primary Member Phone: ( ) _____ ALT Phone: ( ) _____

Authorized Signer of Credit/Debit/Ach **Name:** _____

Address: _____

If different than Primary Member

_____
City State Zip

Authorzied Signer E-Mail: _____ Phone: _____

I, _____ Representing _____
Authorized Credit/Debit/ACH Name Enrolled Member/Family Name

hereby authorize one initial charge of **$65.00** (enrollment fee) and a recurring monthly charge to payment method listed below of **$** _____ (TOTAL OF COLUMNS A & B) to be billed after the completion of the calendar month for which a DirectCareMD Agreement is in force.

		Col A			Col B
PRIMARY CARE			PRIMARY CARE WITH EXTENDED LAB/X-RAY		
____ # of Adults age 20-44 @	$50.00 [=]	$ _____	____ # of Adults age20 - 44 @	$ 80.00 [=]	$ _____
____ # of Adults age 45 - 65 @	$ 60.00 [=]	$ _____	____ # of Adults age 45 - 65 @	$ 90.00 [=]	$ _____
____ # of Children age 0 - 5 @	$ 35.00 [=]	$ _____	____ # of Children age 0 - 5 @	$ 50.00 [=]	$ _____
____ # of Children age 6 - 19 @	$ 20.00 [=]	$ _____	____ # of Children age 6 - 19 @	$ 35.00 [=]	$ _____
Sub-Total of Column A		$ _____	Sub-Total of Column B		$ _____

TOTAL of Columns A & B $ _____

(Charges are usually processed within the first 5 days of the next calendar month).

The initial number of enrollees is: _____ Notice to DirectCareMD of additional enrollees or discontinued enrollees shall constitute a modification of this request to adjust the monthly billing accordingly.

The credit card to be billed is: ___ MC ____ VISA ___ AE _____ DISCOVER

Credit Card Number is: _____ Exp: _____

NOTE: This charge will be processed by and the entry on your statement will read "DirectCareMD"

ACH Check Bank Routing # _____ Account # _____

NOTE: This charge will be processed by and the entry on your statement will read "Heritage Family Medicine"

_____ _____
Authorized Credit/Debit/ACH Signer Signature Date

I have read and understand the DirectCareMD Agency Agreement, herein incorporated by reference, and agree to its terms.

_____ _____ _____
Primary Member Printed Name Primary Member Signature Date

Acknowledged on behalf of DirectCareMD by:

_____ _____ _____
Name Position Date

Rev. 1/2018