



Patient Application

Please Print All Information

Physician _____ Date _____

PATIENT NAME Mr. Mrs. Ms. Dr.

Gender Male Female

First Name _____ Middle Initial _____

Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone: Home (____) _____ Office (____) _____ Cell (____) _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Insurance Carrier & Type (e.g., XYZ Ins/PPO) _____

This program is eligible for reimbursement through section 125 plans, FSAs, HSAs, etc.

Do you plan to use any of these to offset your annual fee? Yes _____ No _____

If yes:

Employer Name _____

Street Address _____

City _____ State _____ Zip _____

BILLING

You may pay for your annual fee of \$1,500 with either a check or credit card. Please make your checks payable to your physician.

Annual Payment Semi-Annual Payment Quarterly Payment

Check Enclosed VISA MasterCard Discover American Express

Name As It Appears On Card _____

Card # _____

Expiration Date _____ Billing Zip Code _____

PATIENT SIGNATURE _____

Referred By _____