

Member Enrollment

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| MEMBER INFORMATION |
| Last Name:       | First:       | Middle:       |
| Birth Date:MM /DD/YYYY  |    /    /      | Gender: [ ]  Male [ ]  Female  |
| Home Address:      |
| City:      State:      Zip:       |
| Phone: (     )     −       [ ] Home [ ]  Cell  | Phone: (     )     −       [ ] Home [ ]  Cell  |
| Email address:      |
| Agreements |
|  [ ] I have received a copy of the Retainer Medical Agreement/Direct Primary Care Agreement |
| Enroll Spouse/Dependent |
| Last Name:       | First:       | Middle:       |
| Birth Date:MM/DD/YYYY |     /    /      | Gender: [ ]  Male [ ]  Female  |
| Phone: (     )     −       [ ] Home [ ]  Cell  | Phone: (     )     −       [ ] Home [ ]  Cell  |
| Email address:      |
| Enroll Additional Members in Household |
| **Dependent** |

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| Last Name:       | First:       | Middle:       |
| Birth Date:MM/DD/YYYY |     /    /      | Gender: [ ]  Male [ ]  Female  |
| Alternate phone (if different than above: (     )     −       [ ] Home [ ]  Cell  |
| Email address:      |

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| **Dependent** |

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| Last Name:       | First:       | Middle:       |
| Birth Date:MM/DD/YYYY |     /    /      | Gender: [ ]  Male [ ]  Female  |
| Alternate phone (if different than above: (     )     −       [ ] Home [ ]  Cell  |
| Email address:      |

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| **Dependent** |

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| Last Name:       | First:       | Middle:       |
| Birth Date:MM/DD/YYYY |     /    /      | Gender: [ ]  Male [ ]  Female  |
| Alternate phone (if different than above: (     )     −       [ ] Home [ ]  Cell  |
| Email address:      |

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| **Dependent** |

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| Last Name:       | First:       | Middle:       |
| Birth Date:MM/DD/YYYY |     /    /      | Gender: [ ]  Male [ ]  Female  |
| Alternate phone (if different than above: (     )     −       [ ] Home [ ]  Cell  |
| Email address:      |

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**Membership Billing Information**

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| Billing Information |

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| Payment Schedule: |  [ ]  Monthly [ ]  Quarterly [ ]  Annual  | **Enrollment fee of $85.00 per houshold** *(one-time fee with no lapse in membership, non refundable.)* |
| **Monthly Pricing:** | 1 [ ]  *or* 2 [ ]  Individual age 27 - 65 $69.001 [ ]  *or* 2 [ ]  Individual age 66 + $79.00 [ ]  Independent youth $50.00 *(age 18 - 25, individual membership)* | [ ]  1 Adult, 1 child *(under age 26)* $84.00[ ]  Family 2 Adults, $158.00 *(up to 2 child thru age 25)*       Additional child $15.00 each *(enter number)* |
| Desired Payment Date: |  [ ]  1st [ ]  5th | **Payment Method (choose one**) [ ]  Credit or Debit Card [ ]  Bank Account  |

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| Card type: [ ]  CC **or** [ ]  HAS/FSA *(all cards accepted)* |  | Bank Account Information |
| Cardholder’s name:       |  | Account holders name:       |
| Card number:                     |  | Bank name:       |
| Expiration Date: MM/YYYY |     /      |  | Account number:       |
| Security Code:       |  | Routing number:       |
|  [ ]  Authorization Sttement: I authorize Nicc’s Direct Primary Care, to charge my credit card, debit card, HSA/FSA card or bank account for an $85.00 one-time enrollment fee and on a recurring basis for my Retainer Medical Agreement/ Direct Primary Care Membership per the above selected frequency until I have cancelled my membership in writing with 30 days notice. If my credit card company or bank delince charges my membership is cancelled immedicately until I make another payment and may be subject to a re-enrollment fee. I also agree to pay a $25.00 NSF for any returned payment.[ ]  I understand that insurance will not be billed for services covered under my membership. |   http://kwc.edu/_uploads/sites/2/Check-Example.gif |
| Authorization Signature:       | Date:    /    /      |

Email completed form: admin@niccdpc.com Or mail: 4509 S. 6th Street, Suite 301 / Klamath Falls OR 97603