ID#:_____________ (to be assigned)

Platinum Family Medicine Membership Application

Effective Month: ____________

Applicant's Name: ________________________________ Date of Birth: ___/___/___ M___F___

Home Address: ________________________ City: _____________ State: _______ zip: _______

Home Phone: ________________ Cell Phone: ________________ Work Phone: ______________

E-Mail Address: _______________________________________

*Billing Address: _________________________ City: __________ State: ________ zip: _________

Please circle the plan would you like to join:

Silver **Gold** **Platinum**

Please circle the method of payment:

Credit Card **Check** **Cash**

Name (as it appears on credit card): ____

Expiration date of credit card: _____________________ Credit Card #: ____________________

Billing Zip Code:_________________ Security Code:___________________

I have read the contract and agree to the terms. I am permitting Platinum Family Medicine to charge my credit card on the 1st of every month equal to the amount of monthly membership dues. Cash payments must be made at any of our office location.
If the applicant is a minor, then the application must be signed by a parent or guardian.

Applicant Signature: ____________________________ Date: ___/___/___

Name (in print): Relation to Minor ____

Name of referring person _______________________________

Please send the completed application with appropriate payment to:

Platinum Family Medicine P.C.
765 Route 25A
Miller Place, NY 11764

Bank Name: ____

Account Number:____

Routing Number:____

Name as it appears on account:_______________________________

Electronic funds transfer debits and/or credits from the account identified below for payments due or when applicable, apply electronic funds transfer credits to the same.
Furthermore, if any such electronic debit(s) should be returned by my financial institution as unpaid (Non-Sufficient or Uncollected Funds), I authorize, ____________________________ (MERCHANT), to collect a returned item fee of $25.00 (or the maximum amount allowed by state law) per item by electronic debit from the same account identified below.

For accounting purposes, all electronic debits will be reflected on the monthly bank statement that corresponds with the financial institution account identified below.

I understand and authorize all of the above.

AUTHORIZING SIGNATURE DATE ___/___/___

PRINT NAME ____

This authorization is to remain in full force and effect until MERCHANT has received written notification of its termination in such time and in such manner as to afford MERCHANT a reasonable opportunity to act on it or the until the term of the authorization expires. Any such notice should be sent to the following address:

Financial Institution account "identifying information": Enter financial institution account information in the fields provided below or attach a blank VOID check.