Patient Enrollment Form for Gebhart's Concierge and Consult

Monthly or Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of this Patient Enrollment Agreement Form.

_____

Head of Household Name Date of Birth (MM/DD/YYYY) Age

_____

Street Address City, State, Zip

_____ _____ _____ _____

Home Phone Work Cell Preferred Email

_____

Spouse Name Date of Birth (MM/DD/YYYY) Age

_____ _____ _____ _____

Home Phone Work Cell Preferred Email

Child/Children to Whom this Agreement Applies:

_____

Print Name Date of Birth (MM/DD/YYYY Age

_____

Print Name Date of Birth (MM/DD/YYYY) Age

_____

Print Name Date of Birth (MM/DD/YYYY) Age

_____

Print Name Date of Birth (MM/DD/YYYY) Age

Preferred Payment Method

□ Yearly (Check or Credit/Debit Card) □ Monthly (Credit/Debit Card)

I certify that I have read, understand, and agree to the terms set forth in this Agreement Form. I further certify that I have received a copy of this form.

Signature_____Date_____