ENROLLMENT FORM

FIRST NAME:___________________________________

LAST NAME: ___________________________________

ADDRESS:____

CITY: _______________________________ STATE: _____________ ZIP: ___________

PRIMARY PHONE #: ___________________ SECONDARY PHONE #:_______________

DATE OF BIRTH: ___________________ GENDER: MALE _______ FEMALE _______

WHEN DO YOU WANT TO START YOUR AMERICANA DPC MEMBERSHIP?

MONTH: ____ YEAR: __________________

DO YOU CURRENTLY HAVE A PRIMARY CARE PROVIDER? YES _____ NO_____

IF YES, DO YOU WANT TO THE LIBERTY CLINIC TO SEND MEDICAL RECORDS

INCURRED AT THE LIBERTY CLINIC TO YOUR PCP? YES _____ NO_____

IF YES, PLEASE PROVIDE YOUR PCP'S NAME AND CONTACT INFO:

____

I ALLOW THE LIBERTY CLINIC TO CHARGE MY CREDIT CARD OR DIRECT DEBIT MY BANK ACCOUNT $50 PER MONTH.

MEMBER'S SIGNATURE: __________________________________ DATE: ___________

BANK ACCOUNT INFORMATION

NAME ON BANK ACCOUNT: _______________________

ROUTING #:_____________________________________

ACCOUNT #: ____________________________________

CREDIT CARD INFORMATION

NAME ON CREDIT CARD: __________________________

CARD #:____

EXPIRATION DATE: _________________ CVV: ________

TERMINATION AGREEMENT. I understand that I must give notification by the 20th day of the month via phone or email to The Liberty Clinic in order to terminate this agreement by the first day of the following month.