Well Primary Care
Enrollment and Billing Authorization

Enrollment			
Name:	Enrollment date/billing start date: ____/____/____		
Additional family members included in this enrollment:			
Registration fee:	$75 single / $100 family (2 or more)		**= $ _____**
Monthly fee:	____ people age 14-24 ____ people age 25-49 ____ people age 50+	@ $40/month @ $75/month @ $100/month	= $ _____ = $ _____ = $ _____
	Total monthly subscription:		**= $ _____**

Billing (choose 1 of 2 options)*	
OPTION 1: Automatic transfer from bank account	
Name on account:	[ ] Checking [ ] Savings
Bank Name:	Routing Number:
** Please attach a voided check to this form, thank you. **	
OPTION 2: Recurring charge to Credit or Debit Card	
Name on card:	[ ] Visa [ ] MC [ ] Discover [ ] Am Ex
Card #: _____ _____ _____ _____	Expiration Date: ___/___
3-digit security code: _____	Billing zip code: _____

Authorization
● I hereby authorize Well Primary Care to charge my credit card, debit card or bank account for my registration, periodic membership fee, and any incidental fees that I incur or have incurred on my account since my last billing date for myself and my registered family members. ● I understand that a $25 fee will be charged to me for a declined credit card, debit card or for an automatic funds transfer transaction that is not honored. ● I understand that I may cancel my membership at any time as outlined in the Patient Agreement.
Account Holder **Signature**: **Date:**

* If you prefer a non-automated payment method (for example, writing a periodic check) please let us know and we can set that up for you.