James J. Biemer, Jr., MD, FACP

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Enrollment Form

Fee:	Annual:	Monthly Payments:
Individual	$660	$55
Couple	$1200	$100
Additional family members 26y.o. & over	$400	$33
Additional members ages 16-25y.o.*	$250	$20 (*fee waived if college student)

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

List Additional Patients Included in Program: _____

_____

Monthly payments may be paid **ONLY** by automatic credit/debit card withdrawal on either the 5th, 15th or 25th of every month.
**Please automatically debit my account for the amount listed below on the date chosen below:
(initial payment option below)

_____ please debit $_____ on the 5th of every month.

_____ please debit $_____ on the 15th of every month.

_____ please debit $_____ on the 25th of every month.

Annual payment may be made by cash, check or credit/debit card.
(Please initial payment option below)

_____ I have enclosed my cash/check (circle one) for the amount of $_____.

_____ Please bill my credit/debit card in the amount of $_____.

Credit /Debit Card Information (we accept Visa, MC, AMEX & Discover)

Card Number: _____
Expiration Date: _____/_____ CVV(3 digit code on back of card): _____

Signature: _____ Date:_____

Office Use Only		
Start Date	Program Type Individual Couple Family	Amount Charged
Billing Interval	Comments	