ADVANCED HEALTH
& WELLNESS

PRIMARY CARE MEMBERSHIP — ENROLLMENT FORM

Office use / patient enrollment packet

1. Primary member

Full legal name _____

Date of birth _____

Phone _____

Email _____

Mailing address _____

Preferred contact method _____

Emergency contact and phone _____

2. Select membership

☐ Adult individual — $100/month

☐ Youth under 18 — $50/month (parent/guardian required)

☐ Couple (two adults) — $175/month

☐ Couple + children — $175/month plus $50/month per child under 18

☐ Other household composition (calculate from applicable individual rates)

One-time enrollment fee: $100 per household. Memberships and household eligibility subject to approval of final program terms.

3. Household members to enroll

Name	DOB	Relationship	Adult / Youth

Attach an additional page if needed. Parent/legal guardian must sign for each minor.

4. Acknowledgment

I request information and enrollment in the proposed primary care membership program. I understand that enrollment is subject to acceptance and a signed membership agreement, and that membership is not health insurance.

Applicant signature / date _____

Parent or guardian signature / date (if applicable)

_____

MEMBERSHIP PRICING & PAYMENT AUTHORIZATION

Office use / patient enrollment packet

Membership calculation

Number of adults _____

Number of youths under 18 _____

Monthly membership total _____

One-time household enrollment fee: $100

_____

Amount due at enrollment _____

Requested start date _____

Billing date (day of month) _____

Pricing: Adult $100/month; youth under 18 $50/month; two-adult couple $175/month; couple plus youth $50/month per child. Discounts for other household structures are not established.

Payment method (secure processing only)

☐ Card or bank account on file through approved payment processor

☐ Alternative payment method arranged with office

Do not write full card numbers, bank account numbers, or security codes on this form. Enter payment credentials only through the practice's approved secure payment system.

Recurring payment authorization

I authorize Advanced Health & Wellness to charge the payment method I separately provide through its secure processor for the agreed monthly membership amount and applicable one-time enrollment fee. I understand the amount and billing date will be confirmed before my first charge. I may revoke authorization for future payments by contacting the practice, subject to the signed membership agreement and applicable law. Revoking payment authorization does not itself resolve any amount already owed.

Account holder name _____

Account holder signature / date _____

Office use

☐ Membership rate verified

☐ Household fee collected

☐ Secure payment authorization saved

☐ Signed agreement on file

☐ Welcome information provided