Essential Health Access, P.A.

Member Agreement & Disclosure

Member Registration Form

Patient Information

Last Name:_____First Name:_____MI:__ DOB: _____Male__ Female___

Home Address:_____City:_____State:_____Zip:_____

Billing Address: _____City:_____State:_____Zip:_____

Phone # 1 (___)_____Home___Work___Cell____Phone #2:(___)_____Home___Work____Cell___

Email Address: _____Employer:_____

Emergency Contact: Phone: (___)_____Relationship:_____

Membership

Membership Start Date: _____

How did you hear about Essential Health Access? Internet Search_____Personal Referral_____TV/Radio Print Publication_____ Other_____

Other (please list):_____

Billing

OPTION A: Credit Card or Debit Card *

Name on Card:_____3 Digit Code on Back of Card:_____

Card Type: Visa_____MasterCard _____Discover _____American Express _____

Card Number:_____ Expiration:_____

Card Billing Address:_____ ZIP Code:_____ *Same as home.*_____

_____Yes, please add me to the billing account of an existing Essential Health Access patient associated with the above credit card.

OPTION B: Automatic Funds Transfer ** *Please note that it takes approximately 3 days from the payment processing dale before the charge posts to your account*

Name on Account _____

Bank Name:_____Account Type: Checking_____Savings,_____

Account Number:_____Bank Routing Number: _____

Please attach a voided check to this form

Note: * a 2% fee may be added to credit or debit card transactions depending on authorization fees ** Automatic Funds Transfer not available at this time

Authorization

Your monthly membership fee covers the services specifically described in the Essential Health Access (EHA) Membership Packet. Your care may require incidental services that are not covered by your monthly membership fee. Please note that by providing the above billing information you authorize EHA to charge your card or draw on your bank account for any incidental items at the time of service.

- By signing below, I hereby authorize EHA to contact me using the information I have provided above. By signing below, I hereby authorize EHA to initiate charges to my bank account, debit, or credit card for my monthly membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my membership fee plus the membership fees of any individuals on my account.
- This authorization to perform monthly charges to my bank account, debit or credit card will remain in full force and effect until EHA has received written notification from me of its termination in such time and in such manner as to afford EHA and my financial institution a reasonable opportunity to act on it.
- I understand that my membership in EHA is continuous and that, by signing below, I authorize recurring automatic credit/debit card charges or funds transfers.
- I understand that a $25 fee will be charged to me for declined credit, debit or automatic funds transfer transactions that are not honored.

Account Holder Signature: _____Date:_____