DISCOUNT MEMBERSHIP APPLICATION

First Name: ___________________ MI: __________ Last Name: ____________________

Date of Birth: __________________________

E-mail Address: ____________________________________ Gender: _________________

Street Address: ____

City: ____________________ State: _____________ Zip: _______________

Day Time Phone: ______________________ Evening Phone: _______________________

Membership Fee per Family (Please select one):

____________ $18 Monthly ________________$185 Annually

Note: There is a one time $5 fee for processing your application.

* As a member of our discount program you and your family members listed below will receive regular office visits for $65 and office visits with procedures for $115 (these procedures are listed in our brochure) at both Rocky Mountain Urgent Care and Potomac Square Family Medicine. In addition, members will receive discount vision, dental, physician/hospital, and pharmacy benefits.

Family Members:
Please include these family members with my membership (may include spouse and legal dependents).

First	Last	Relationship	Date of Birth

Payment can be made either by credit card or bank draft:

Credit Card

Cardholder Information:

First name: ____________________________ Last Name: __________________________

Billing Address: ____

City: ____________________ State: _____________ Zip: ______________

Credit Card Information:

Credit Card Type: _________ Account Number: _________________________________

Expiration Date: ________________

Bank Draft:

Account Owner Information:

First Name: ___________________________ Last Name: _________________________

Bank Account Information:

Routing Number: ______________________ Account Number: __________________

Bank Name: __________________________ Branch Location: ___________________

Please attach a voided check.

I hereby authorize Rocky Mountain Urgent Care to charge the Credit Card account or Checking Account selected above. A recurring membership fee will be charged to my account monthly or annually depending upon the membership type selected above.

____
Signature Date

Disclosures

- **This is NOT insurance**
- **This discount card program contains a 30 day cancellation period**
- **This discount program is only available in Colorado**
- **Hospital discounts are NOT available in Maryland**