Personalized Health Care
Membership Application

PATIENT NAME ___Mr. ___Mrs. ___Ms. ___Dr. **Gender** ___Male ___Female

First Name _____ Middle Initial _____

Last Name _____

Street Address _____

City _____

Phone: Home (____) _____Office (____) _____Cell (____) _____

Date of Birth _____

E-mail Address _____

Insurance Carrier & Type (e.g. XYZ Ins/PPO) _____

This program is eligible for reimbursement through most section 125 plans, FSAs, HSAs, etc.

Do you plan to use any of these to offset your annual fee? Yes _____ No _____

Employer Name _____

Job Title _____

BILLING

Please indicate which payment plan you would like and whether you wish to pay by check, credit card or checking account auto debit.

Payment Plans ___ Annual Payment ($1800) ___ Semi-Annual Payment ($900)

___ Quarterly Payment ($450)

Method of Payment

___ Check (Please make your check payable to Dr. John Padour)

___ Credit Card: ___ Visa ___ MasterCard ___ Discover ___ American Express

Credit Card # _____ Expiration Date _____

___ Checking Account Auto Debit - Call office for details.

This agreement will be automatically renewed and the credit card you used to join this program will be charged per the billing cycle selected above.

PATIENT SIGNATURE _____ Date _____

Referred by _____