



**Physicians Immediate Care  
Medical Membership Plan Application**

Subscriber Information-Print Clearly

Your Last Name _____	First Name _____	Initial _____	Requested Start Date _____
Street Address _____	City _____	State _____	Zip _____
Social Security Number _____	Telephone Number w/Area Code _____	Date of Birth _____	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married			
E-Mail Address _____			

If you wish to apply for membership for a spouse and/or unmarried children who are under age 18, please list them on the second page of this application. Provide last name if different from yours. **Number of members applying:** \_\_\_\_\_

How did you hear about our Medical Membership Plan: \_\_\_\_\_

Member Plan Liability

- Patients joining the plan must agree to see a specialist physician when a medical problem is outside the scope of general medical care or for pre-existing conditions requiring a specialist as determined by our practitioners. \_\_\_\_\_ Initials
- Patients with complicated medical conditions (i.e. diabetes, heart failure, seizure disorder, cancer, etc.) will be required to continue to follow up with their specialist based on the recommendations from the specialist. The physicians at Physicians Immediate Care will work in conjunction with the specialist to ensure quality care, follow up care and medicine refills when appropriate. \_\_\_\_\_ Initials

Membership Fees

Individual	\$49.00		Totals
Each additional member	\$39.00	X _____ additional members	\$ _____
Utilization Fee per visit	\$20.00		
Replacement Card	\$5.00		
			<b>Today's Total Cost</b> \$ _____

\*Additional services are available which are not included in monthly plan fee/utilization fee.

This is an authorization to automatically renew your thirty day membership on a month to month basis or your annual membership on a yearly basis until cancellation.

Auto-Recurring Payment Authorization Form

**Please complete the information below:**

I authorize Physicians Immediate Care to charge/debit my account on the date of this application a one time only payment in the amount of \$ \_\_\_\_\_ for first and last month of my Medical Membership Plan and then monthly recurring payments thereafter of \$ \_\_\_\_\_ on the first day of each month for the entire duration of membership.

**Checking Account Info:**

Bank Name: \_\_\_\_\_  
 Account Number: \_\_\_\_\_  
 Bank Routing #: \_\_\_\_\_  
 Bank City/State: \_\_\_\_\_  
 Driver's License #: \_\_\_\_\_

If you are unsure of your account's routing number, please contact your bank for that information.



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**Member Information**

**MEMBER 1**

_____ Last Name	_____ First Name	_____ Initial	_____ Account #
_____ Street Address	_____ City	_____ State	_____ Zip
_____ Social Security Number	_____ Telephone Number w/Area Code	_____ Date of Birth	
_____ <input type="checkbox"/> Male <input type="checkbox"/> Female		_____ <input type="checkbox"/> Single <input type="checkbox"/> Married	

**MEMBER 2**

_____ Last Name	_____ First Name	_____ Initial	_____ Account #
_____ Street Address	_____ City	_____ State	_____ Zip
_____ Social Security Number	_____ Telephone Number w/Area Code	_____ Date of Birth	
_____ <input type="checkbox"/> Male <input type="checkbox"/> Female		_____ <input type="checkbox"/> Single <input type="checkbox"/> Married	

**MEMBER 3 (Minor/Child)**

_____ Last Name	_____ First Name	_____ Initial	_____ Account #
_____ Street Address	_____ City	_____ State	_____ Zip
_____ <input type="checkbox"/> Male <input type="checkbox"/> Female			_____ Date of Birth

**MEMBER 4 (Minor/Child)**

_____ Last Name	_____ First Name	_____ Initial	_____ Account #
_____ Street Address	_____ City	_____ State	_____ Zip
_____ <input type="checkbox"/> Male <input type="checkbox"/> Female			_____ Date of Birth

I agree to notify Physicians Immediate Care in writing of any changes in my account information or termination of this authorization. I understand that cancellations must be made in writing. Member authorizes Physicians Immediate Care to debit the account for all sums owing to Physicians Immediate Care including monthly payments, initial processing fee. If auto payment is interrupted and non obtainable for any reason the member's membership benefits are immediately cancelled on the monthly or annual renewal date which ever applies. This membership is not transferable and member may not sell, assign or transfer this agreement, his/her membership card or membership in Medical Membership Plan or any other right or privilege and any such attempted sale, assignment or transfer shall be null and void. Member must present his/her picture membership card on each visit. I have fully informed Physicians Immediate Care that I **do not** have insurance or have insurance that Physicians Immediate Care **does not** participate with. I am responsible for full payment of "Time Of Service" fees **at the time of service**. I also release Physicians Immediate Care from any billing issues in the future with insurance companies or others concerning "TOS" charges.  
"I have read and understand and agree with the above statements."

»SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



**Physicians Immediate Care  
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**Patient Medical History**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Surgical History:** please list all surgeries

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Allergies to Medications/ Reactions to Medications**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Current Medications**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**Health History**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Head/Brain injuries, disorders or illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy <input type="checkbox"/> medication	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disorders or impaired vision (except corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery (valve replacement, bypass, angioplasty, pacemaker)	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders, e.g. severe depression <input type="checkbox"/> medication
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure <input type="checkbox"/> medication	<input type="checkbox"/>	<input type="checkbox"/>	Loss of or altered consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis (CVA/TIA)
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot leg, finger, toe
<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Regular, Frequent alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit forming drug use
<input type="checkbox"/>	<input type="checkbox"/>	Regular, Frequent tobacco use			

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_