Care Card Membership™ Application

Account #: ___________

Patient Name: ______________________ ______________ ______________________________
First Middle Last

Address: ____________________________________ ______________________ ____________ ________
Street City State Zip

Birth Date: ____________ SS#: __________________ Home Phone #: ______________ Cell Phone #: ______________

E-Mail: __________________ Additional Family Members applying: ______________________________________

How did you hear about Care Card Membership™?: ______________________________________

Fees

	App Date	Start Date		Monthly	Annual	
Non-Refundable Processing Fee			$30.00			
Dues						________
Individual	________	________		$35.00	$378.00	________
Couple	________	________		$70.00	$756.00	________
Family	________	________		$125.00	$1350.00	________
Replacement Card			$10.00			________
Cancellation Fee			$20.00			________
Total Fees						________

This is an authorization to automatically renew your thirty day membership on a month to month basis which becomes effective on the seventh (7th) day from your join date. Member agrees to give fifteen (15) days written notice of cancellation effective after the seventh (7th) day from join date has been completed. Member acknowledges that he/she is liable for all fees and bank charges related to member's Care Card Membership transactions.

» SIGNATURE: ______________________________ INITIALS: ______ DATE: ______________

Auto-Recurring Payment Authorization Form

Please complete the information below:

I » ______________________________ authorize Complete Care Center to charge/debit my account on the date of this application a one time only payment in the amount of $__________ for initial Processing Fee and first month payment of my Care Card Membership™ and then monthly recurring payments for the second month and thereafter of $__________ on the __________ day of each month for the entire duration of membership.

Account Type: ☐ Checking ☐ Credit Card

Checking Account

Bank Name: ______________________
Account Number: ______________________
Bank Routing #: ______________________
Bank City/State: ______________________

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

Credit Card

☐ Visa ☐ MasterCard ☐ American Express

Cardholder Name: ______________________
Acct #: ______________________
Exp. Date: __________ CCV: __________
Billing Address: ______________________
City, State, Zip: ______________________
Phone #: ______________________

I agree to notify Complete Care Center in writing of any changes in my account information or termination of this authorization 15 days prior to the next due date of the charges. I understand that cancellations must be made in writing. Member authorizes Complete Care Center to debit the account for all sums owing to Complete Care Center including but not limited to administration fees, late fees, or any other delinquent amount and all taxes enacted by the state of Michigan or any governing authority. 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.

Membership: This membership is not transferable and member may not sell, assign or transfer this agreement, his/her membership card or membership in Care Card or any other right or privilege and any such attempted sale, assignment or transfer shall be null and void. Member may not loan his/her membership card to anyone

» SIGNATURE: ______________________________________ DATE: ____________________

I » ________________________ have fully informed Complete Care Center that I do not have insurance or have insurance that Complete Care Center does not participate with. I am responsible for full payment of "Time Of Service" fees at the time of service. I also release Complete Care Center 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 statement."

» SIGNATURE: ______________________________________ DATE: ____________________

Care Card Membership™