



MEMBER REGISTRATION FORM

This form can be completed in paper form or online. It should be completed for each family member. To become a member, in addition to this form, you need to complete a Release of Records Form, the Membership Contract, and the Medicare Private Contract (if Medicare eligible).

Name: _____ Date of Birth: _____

Gender: Male Female

Email: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

How did you hear about us? _____

Membership fee

- Adult: \$41 joining fee, \$41/month membership fee, \$20 visit fee
- Child (under 18 with parent): \$21 joining fee, \$21/monthly fee, \$20 visit fee

Payment

- Automatic payment from bank account (ACH) - include voided check
- Credit Card:
 - Visa MasterCard

Name: _____

Card Number: _____ Exp: _____

CVC code (from back of card): _____

Signature: _____

When complete, paper form can be faxed to (937) 404-2428 or mailed to Hickory Medical Direct Primary Care, LLC, 208 West Columbus Ave, Bellefontaine, OH 43311