ENROLLMENT AND BILLING AUTHORIZATION
Freedom Primary Care, LLC

Pursuant to the Direct Primary Care Patient Agreement, the following First Family Member who is signing below, requests enrollment for him/herself and Family Members for ongoing primary care services:

First Family Member:

Name:	
Date of Birth:	
Address:	
Phone Number:	
Preferred Email:	

Additional Family Members (spouse, children, or dependent relatives who reside in the first family member's household):

Name (relationship)	Date of Birth	Phone

Payment Authorization**: I authorize the following monthly transaction of:

_____ $50 (1 member)	_____ $100 (3 members)	_____ $150 (family max)
_____ $75 (2 members)	_____ $125 (4 members)	

Credit Card Number	Expiration Date	CVV Code

Authorized Signature: _____