KENAM HEALHCARE LLC – A DPC PROVIDER

Enrollment and Billing Authorization

Enrollment	
Name:	Enrollment date/billing start date: ____/____/____
Additional family members included in this enrollment:	
Registration fee: $50 single / $100 family (2 or more)	= $ ________
Monthly fee: ____ people age 14-25 @ $35/month	= $___________
____ people age 26-39 @ $60/month	= $ __________
____ people age 40-50 @$75/month	= $ __________
____ people age 51-65 @$85/month	= $ __________
____ people age 66 and above+ @$95/month	=$ __________
Total monthly subscription:	= $ ________

Billing (choose 1 of 2 options)*	
OPTION 1: Automatic transfer from bank account	
Name on account:	[ ] Checking [ ] Savings
Bank Name:	Routing Number:
** Please attach a voided check to this form, thank you. **	
OPTION 2: Recurring charge to Credit or Debit Card	
Name on card:	[ ] Visa [ ] MC [ ] Discover [ ] Am Ex
Card #: _____ _____ _____ _____	Expiration Date: ___/___
3-digit security code: ______	Billing zip code: ______________

Authorization	
● I hereby authorize KENAM HEALTHCARE LLC to charge my credit card, debit card or bank account for my registration, periodic membership fee, and any incidental fees that I incur or have incurred on my account since my last billing date for myself and my registered family members. ● I understand that a $25 fee will be charged to me for a declined credit card, debit card or for an automatic funds transfer transaction that is not honored. ● I understand that I may cancel my membership at any time as outlined in the Patient Agreement.	
Account Holder Signature:	Date:

* If you prefer a non-automated payment method (for example, writing a periodic check) please let us know and we can set that up for you