ATLAS MD

Patient Enrollment
AtlasMD Concierge Family Practice

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the AtlasMD Agreement Form.

Printed Name Date of Birth (MM/DD/YYYY) Age

Street Address City, State, Zip

Home Phone Work Phone Cell Phone Preferred email

Spouse Name Date of Birth (MM/DD/YYYY) Age

Home Phone Work Phone Cell Phone Preferred email

Child/Children to Whom this Agreement Applies:

Print Name Date of Birth (MM/DD/YYYY) Age

Print Name Date of Birth (MM/DD/YYYY) Age

Print Name Date of Birth (MM/DD/YYYY) Age

Print Name Date of Birth (MM/DD/YYYY) Age

Preferred Payment Method

☐ Yearly (Check or Credit/Debit Card) ☐ Monthly (Credit/Debit Card) ☐ Employer_____

I certify that I have read, understand, and agree to the terms set forth in the AtlasMD Agreement Form. I further certify that I have received a copy of this form.

Signature: _____