



Name: _____

Address: _____ Pagosa Springs, CO 81147

Phone Number: _____ Cell Phone : _____

E-Mail Address: _____

Date of Birth: ____/____/____

How did you hear about us? Physician _____ (name) Newspaper Friend
Online Source Facebook Other

Membership Options:

1) Monthly Debit from Account - \$45.00 per month (3 month minimum, Credit/ debit only)

By choosing this option and signing this form, I hereby authorize Pagosa Springs Medical Center, to initiate debit entries as indicated to my Credit/ Debit Account listed below. I acknowledge that the origination of the ACH transactions to my account must comply with the provisions of U.S. and State Law. Furthermore, if any such debit(s) should be returned NSF, I authorize Pagosa Springs Medical Center to collect such debit(s) by electronic debit and subsequently collect a returned debit NSF fee of \$30.00 per item by electronic debit from my account identified below. I am a duly authorized signer on the credit/ debit account identified below, and authorize all of the above as evidence by my signature below.

Credit/ Debit Information:

Card Type: VISA/ MC/ AMEX (circle) Credit/ Debit Card Number: _____

Expiration Date: ____/____ 3 Digit Security Code: _____

The amount of \$45.00 will be debited from the above account on the 5th day of every month.

The prorated amount of \$_____ (\$1.50/day) will be a one-time debit on _____(date).

This authorization shall remain in force and effect until Pagosa Springs Medical Center receives *written notification* from me of termination with *at least 14 days* of anticipation of the next transaction, to afford Pagosa Springs Medical Center and the Credit/ Debit Account a reasonable opportunity to act and to make necessary adjustments. I understand that Pagosa Springs Medical Center reserves the right to terminate this payment method any my participation in this service.

SIGNATURE: _____

DATE: ____/____/____

2) 6 Month Membership - \$240.00 (paid by cash, check, or credit card)

3) Full Year Membership - \$420.00 (paid by cash, check, or credit card)

(Please include payment for 6 month or full year membership, or provide Debit/ Credit Information for monthly debit transactions. Checks made payable to Pagosa Springs Medical Center.)

