Broadway Concierge Medicine

Concierge Program Membership Information

Your Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Spouse (if Joining): _____ Date of Birth: _____

Signature: _____ Date: _____

Child 1 (if Joining): _____ Date of Birth: _____

Child 2 (if Joining): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Your Home Phone: _____ Work Phone: _____ Cell: _____

Spouse Work Phone: _____ Spouse Cell: _____

Your Email Address _____ Spouse Email: _____

Membership may be paid by check, electronic debit or credit card.

FEE MAY BE PAID ANNUALLY OR INSTALLMENTS. ANNUAL PAYMENTS PAID 30 DAYS BEFORE THE START OF EACH PERIOD

OPTION 1 ANNUAL FEE PLAN PAYMENTS:

Single Annual Membership ☐ **$4000.00**

Family Membership ☐ **$6500.00**
(2 adults & children living at home, ages 15-26)

☐ **Check Enclosed*** ☐ **Mastercard/Visa**** ☐ **AMEX****

**Make checks payable to Broadway Sports & Internal Medicine*
***You authorize your crest or electronic debit to be charged to your account.*

Name as it appears on card: _____

Billing Address: _____
(if different then mailing address)

Credit Card No.: _____

Exp: _____ **Sec Code:** _____

OPTION 2 PAYMENT PLAN MEMBERSHIPS:

Select your payment schedule preference:

Single Membership

Semi Annual	Quarterly	Monthly
☐$2500/6 mo.	☐$1250/qu.	☐$420/mo.

Family Membership

Semi Annual	Quarterly	Monthly
☐ $3750/6 mo.	☐$1875/qu.	☐$625/mo.

Please contact our office at (206) 215-2288 for the appropriate authorization form. We offer both credit card or electronic debit from checking or savings.

As a subscriber I understand and agree:

1. All medical services covered by my health insurance will be billed to my health insurance/plan carrier.
2. I will be responsible for all co-pays and other expenses in connection with any covered services billed to my health insurance as required by my health insurance subscriber agreement with my health insurance plan/carrier.
3. The non-covered services provided by the subscription practice program, per the following legal statement, will not be paid for by my health insurance plan/carrier:

Physician Waiver Notice for the Concierge Practice Fee

Medicare and Healthcare Insurance Carriers will only pay for the service that are determined to be both "covered services" and "reasonable and medically necessary" under the law and/or Medicare and/or the particular insurance plan you have. Medicare and other healthcare insurance plans/carriers will likely not cover these particular subscription practice services or fees because services are neither "covered services" nor "medically necessary" and therefore these services will not be submitted to Medicare or your health insurance plan/carrier and payment for these services will not be made by Medicare or your health insurance plan/carrier.

Signature: _____ Date: _____

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