AGENT CODE# _____ ID#:_____
(to be assigned) (to be assigned)

# AMG MEDICAL GROUP MEMBERSHIP APPLICATION

**Effective Month**: _____

Applicant's Name: _____ Date of Birth: ___/___/___ M___F___

Home Address: _____City: _____ State: _____ zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

E-Mail Address: _____

*__Billing Address__: _____ City: _____ State: _____ zip: _____

**Please circle the *AMG facility that will be used primarily:***

Bronx Brooklyn Manhattan Staten Island Long Island

***CHOOSE A PLAN:***

**___ AMG 59**

**___ AMG 99**

**___ AMG 129**

***Please circle the method of payment:***

1. Credit Card 2. Check 3. Cash 4. ACH

Name (as it appears on credit card): _____

Expiration date of credit card: _____/_____ Credit Card #: _____

I have read the contract and agree to the terms. I am permitting AMG Medical Group to charge my credit card on the 25th of every month equal to the amount of monthly membership dues. If you are paying through ACH, please complete the application below. Cash payments can be made at any of our five locations.
If the applicant is a minor, then the application must be signed by a parent or guardian.

Applicant Signature: _____ Date: ___/___/___

Name (in print): Relation to Minor _____

Name of referring person _____

***Please send the completed application with appropriate payment to:***

AMG Medical Group
535 8th Avenue, 6th FL
New York, NY 10018

# ELECTRONIC FUNDS TRANSFER AUTHORIZATION FORM

Yes, I would like to take advantage of the security and convenience of electronic funds transfer scheduled or periodic payments.

As a duly authorized check signer on the financial institution account identified below, I authorize you to perform

| | |
|---|---|
| BANK NAME | |
| ACCOUNT # | |
| ROUTING # | |
| NAME AS IT APPEARS ON ACCOUNT | |

Electronic funds transfer debits and/or credits from the account identified below for payments due or when applicable, apply electronic funds transfer credits to the same.

Furthermore, if any such electronic debit(s) should be returned by my financial institution as unpaid (Non-Sufficient or Uncollected Funds), I authorize, _____ (MERCHANT), to collect a returned item fee of $25.00 (or the maximum amount allowed by state law) per item by electronic debit from the same account identified below.

For accounting purposes, all electronic debits will be reflected on the monthly bank statement that corresponds with the financial institution account identified below.

I understand and authorize all of the above.

**AUTHORIZING SIGNATURE DATE ___/___/___**

**PRINT NAME _____**

This authorization is to remain in full force and effect until MERCHANT has received written notification of its termination in such time and in such manner as to afford MERCHANT a reasonable opportunity to act on it or the until the term of the authorization expires. Any such notice should be sent to the following address:

**Financial Institution account "identifying information": Enter financial institution account information in the fields provided below or attach a blank VOID check.**