

# AMG MEDICAL GROUP MEMBERSHIP APPLICATION

Effective Month: \_\_\_/1/\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

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: \_\_\_\_\_

**CHOOSE A PLAN:**    \_\_\_ **AMG 59**    \_\_\_ **AMG 99**    \_\_\_ **AMG 129**

Please select 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 25 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

If the applicant is a minor, then the application must be signed by a parent or guardian.

**Applicant Signature:** \_\_\_\_\_

**Name (in print): Relation to Minor** \_\_\_\_\_

**Name of referring person** \_\_\_\_\_

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

**AMG Medical Group  
535 8<sup>th</sup> Avenue 6<sup>th</sup> 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.**