PACIFICA
MEDICINE & WELLNESS

Account Update Form - Billing Information

Enrollment

Enrollment start date: / / (the 1st of next month) One-time registration fee: $

Enrollment type: [**X**] Direct Primary Care

Medical Insurance Company: Insured Family Member:

Insurance ID#: Group ID #:

How did you hear about Pacifica Medicine & Wellness? [ ] Notified by my doctor [ ] Friend [ ] Family member

[ ] Facebook [ ] Newspaper article [ ] Print Advertisement [ ] Other

Billing Preferences

Billing frequency: [ ] Yearly [ ] Monthly

OPTION 1: Credit card or Debit card - Charged on the first of the month

Name on card:

Card type: [ ] Visa [ ]MasterCard [ ] Card number: Expiration: / /

Card billing address: [ ] Same as home 3-digit code:

[ ] Please add me to the billing account of an existing Pacifica Medicine patient associated with the above credit card.

OPTION 2: Automatic Funds Transfer** Charged on the 1st of the month

Please note that it takes up to 3 days from the payment processing date before the charge posts to your bank account.

Name on account:

Bank name: Account type [ ] Checking [ ] Savings

Account number: Bank routing number:

** ***Please attach a voided check to this form***

Authorization

Your monthly subscription fee covers the Direct Primary Care services specifically described in the *Pacifica Medicine & Wellness Patient Services Guide*. At times, however, your care may require durable medical supplies or third-party services that are not covered by your monthly subscription fee. To streamline your appointment check-out please note that by providing the above billing information you authorize Pacifica Medicine & Wellness to automatically charge your credit card or draw on your bank account for any of these additional items at the time of service. In all cases these additional items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Pacifica Medicine & Wellness to contact me using the information I have provided above. By signing below, I hereby authorize Pacifica Medicine & Wellness to initiate charged to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any other individuals on my account.
- I understand that my membership in Pacifica Medicine & Wellness is continuous and that, by signing below, I authorize recurring credit/debit charges or bank account funds transfers.
- I understand that a $25 fee will be charged to me for a declined credit card, debit card or for an automatic funds transfer transaction that is not honored.

ACCOUNT HOLDER SIGNATURE: _____ **DATE:** / /