Patient Application

Physician Name __**Dr. Jeff Unger**_____ ❑ **Single** ❑ **Couple**

First Name _____(M/F) Spouse First Name _____ (M/F)

Last Name_____ Spouse Last Name _____

Date of Birth _____ Spouse Date of Birth _____

Phone: Primary (_____) _____(h/c/w) Spouse Phone: Primary (_____) _____(h/c/w)

Phone: Alternate (_____) _____(h/c/w) Spouse Phone: Alternate (____) _____(h/c/w)

E-mail Address _____

Street Address _____

City, State, Zip Code _____

Dependent _____ (M/F) Date of Birth_____

Dependent _____ (M/F) Date of Birth _____

**Add'l Adult Member _____(M/F) Date of Birth _____

Referral Source:

Notes to Billing Department:

The Program Services (as is defined in the Physician Services Agreement) eligibility for HSA/FSA/HRA funds for payment is a tax issue, therefore, please consult with your accountant or tax advisor. With respect to HRA or FSA funds, it is the Patient's responsibility to secure Program Services eligibility approval from the benefits coordinator.

I agree to the terms and conditions set forth in and acknowledge receipt of a copy of the Physician Services Agreement. With the signature below I acknowledge that I am authorized to sign for all members listed above.

AUTHORIZED PATIENT SIGNATURE _____ Date _____

PHYSICIAN SIGNATURE _____ Date _____

PAYMENT

Individual ❑ Annual: $3,300/year ❑ Semi-Annual: $1,650 2x/year ❑ Monthly: $300/monthly

Couples ❑ Annual: $3,050/yr per person ❑ Semi-Annual: $1,525 2x/yr per person ❑ Monthly: $280/monthly per person

❑ Credit Card Payment (Please circle: Visa/MasterCard/Discover/AmEx) ❑ Check (Check #_____)

After initial payment, the payment schedule will begin on _____based on your payment of choice.

Cardholder Name:	
Billing Address:	Billing Zip Code:
Credit Card Number:	
Expiration Date:	Security Code:

I acknowledge receipt of a copy of this agreement and agree to the terms of the payment plan listed above. I further authorize Cypress to charge my credit card on behalf of Physician for the balance of the service fees owed to Physician and not paid in accordance with the payment schedule selected.

AUTHORIZED PATIENT SIGNATURE _____ Date_____