APPLICATION TO JOIN THE MEMBERSHIP CARE PROGRAM

☐ Individual Plan ($600) ☐ Family Plan ($1,000)

ST. JOSEPH PRIMARY CARE
a ministry of caring

ST. ANN CATHOLIC CHURCH ONLY
4057 US-70 Bus. W., Clayton, NC 27520

Member Information

Member Information			
Last Name:	First Name: M.I.:		Previous Name (If applicable)
Mailing Address: Apt#			City/State/Zip:
Home Phone:	Cell Phone:		Work Phone:
Date of Birth:	Sex: ☐Male ☐Female	Email:	
Marital Status: ☐ Decline ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed			
Employer Name:		Emergency Contact Name:	
Emergency Contact Phone:		Relationship to Patient:	

Additional Information

Additional Information

How did you hear about us?

Additional Member(s)(same household)

Name Date of Birth

_____

_____

_____

Payment (MCP)

Membership Care Program (MCP) & Payment

☐Individual Plan - Annual Membership Fee: $600	Family Plan - Annual Membership Fee: $1,000
☐Health Card: $50	☐Health Card: $75
☐Diamond Option: -Pay in full ($600) -Unlimited office visits -No co pay	☐Diamond Option: -Pay in full ($1,000) -Unlimited office visits -No co pay
☐Gold Option: -Pay with a credit card -$55 monthly auto pay -$20 co pay	☐Gold Option: -Pay with a credit card -$85 monthly auto pay -$20 co pay
☐Silver Option: -Pay with cash or debit card -$220 (3 payments in 3 months) -$20 co pay	☐Silver Option: -Pay with cash or debit card -$350 (3 payments in 3 months) -$20 co pay

Insurance

Insurance Information

Do you have health insurance? ☐ Yes ☐ No Name:

If yes, we will need a copy of your health insurance card. Note: St. Joseph Primary Care is an out-of-network provider. We'll NOT bill your health insurance. We'll provide your health insurance to a third party, i.e. labs, medications, x-ray, and other specialist cares. It's your financial responsibility to pay for these services that provided by a third party (outside of St. Joseph Primary Care).

AUTHORIZATION AGREEMENT FOR AUTOMATED WITHDRAWALS:

I hereby authorize and request STJPC to make withdrawals in the amount listed above. I authorize and request BANK to accept my debit entries initiated by STJPC to such account. This authorization will remain in effect until I revoke authorization by writing to STJPC 10 days prior to my scheduled debit. In the event that an automated banking withdrawal payment is denied, I agree to pay the payment amount plus a $20 service fee within 15 days. I understand that STJPC will try to notify me of payment denial by phone and/or email. If the balance due is not paid within 15 days, I understand that my medical services will be discontinued. If discontinued, my medical services may be restarted only at the discretion of STJPC, and only upon full payment. Automated banking withdrawal payments will not be offered to patients or their immediate family with a history of two (2) automated banking withdrawal payment denials.

Patient Name _____Date:_____

Signature _____Date:_____

I have reviewed a copy of St. Joseph Primary Care's Privacy Notice. _____initials