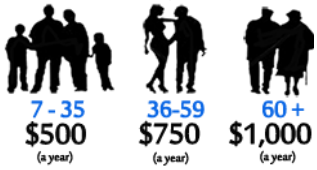
ST. JOSEPH PRIMARY CARE

a ministry of caring

4400 Falls of Neuse Rd., Suite 101 | Raleigh, NC 27609 | (919) 386-6866
4057 US-70 Bus. West | Clayton, NC 27520



Letter of Interest

I am interested in becoming a new member/patient at St. Joseph Primary Care (STJPC).

Sign up Membership Care Program
□ pay in full
□ customize a payment plan
____$50 Recovery fee will be added to your Membership Fee
____Deposit: $200 per person

Type of Membership:	□ Individual	□ Family	□ Corporation & Small business
Membership Fee:	□ $500	□ $750	□ $1,000
Type of Payment:	□ online	□ credit card	□ check
Terms Of Conditions:	□ Accepted	□ Declined	

---

*Note: Upon receipt of this letter and payment, you will be contacted to schedule your first consultation/office visit. Please call (919) 386-6866 with any questions or concerns. Please do not send cash and make a check payable to St. Joseph Primary Care and return this completed form to:

St. Joseph Primary Care
4400 Falls of Neuse Road, Suite 101
Raleigh, NC 27609

Name(s) **Birth date**

1. _____

2. _____

3. _____

4. _____

5. _____

Contact Information

Primary Contact Person_____Email_____

Mailing Address Phone_____

Signed _____Date_____

Automatic Withdrawal Authorization Form

This Automatic Withdrawal Form authorizes St. Joseph Primary Care, Inc. (STJPC) to withdraw fees, including gifts and donations directly from the donor's bank account or credit/debit card. This is a one-year agreement.

Part 1: Designation of Gift

Fees (Membership Care Program)	Annual Membership Fee		
Age: 7-35	$600	+	*$50 (Recovery Fee)(for payment plan only)
Age: 36-59	$750	+	*$50 (Recovery Fee)(for payment plan only)
Age: 60 +	$1,000	+	*$50 (Recovery Fee)(for payment plan only)

*A recovery fee of $50 will be added to the membership for those who want to do a payment plan.

Comprehensive annual wellness visit with 3 essential lab test panels included if the membership fee pay-in-full at the enrollment period.

Tax deductibility of donations governed by applicable state and federal tax law. Some portions of donations may not be deductible due to receipt of clinic services. Clinic will provide annual statements for tax purposes.

Part 2: Authorization for Automatic Withdrawal

Membership Start Date: (mm/dd/yy) _____/_____/_____
Withdrawals will be made based on the agreements between both patients and STJPC as following:

Type of account: ____*Checking ____Savings ____Debit Card (DC)____Credit Card (CC)
[Visa/Mastercard only; no reward/mileage card)

Name (bank/card holder): _____

Routing # (9 Digits): _____ Account (DC/CC) # :_____

For Debit/Credit Card: Expiration date:_____ 3 digits back of the card:_____

*Please attach a voided check to start automatic withdrawal from your checking account OR a deposit slip for a savings account.

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. RETURN TO:

St. Joseph Primary Care | 4400 Falls of Neuse Rd., Suite 101 | Raleigh, NC 27609

Signature: _____Date:_____