



DANIEL GAITAN PERSONALIZED HEALTHCARE

APPLICATION TO PARTICIPATE IN PERSONALIZED SERVICES PROGRAM

Primary Applicant Information

Date: _____

Name:	
Date of Birth:	
E-Mail Address:	
Home Phone:	
Mobile Phone:	
Work Phone:	
Fax Number:	
Street Address:	
City:	
State:	
Zip Code:	

Secondary/Tertiary Applicant

Name:	
Date of Birth:	
E-Mail Address:	
Home Phone:	
Mobile Phone:	
Work Phone:	
Fax Number:	
Street Address:	
City:	
State:	
Zip Code:	

Payment Information

<input type="checkbox"/> Pay by Credit Card
Name on Card: _____
Credit Card Type: _____
Credit Card No.: _____
Expiration Date: _____
Security Code: _____
Billing Zip Code: _____
*Keep Card on File for Automatic Billing: YES NO (Circle One)
<input type="checkbox"/> Pay by Debit Card
Name on Card: _____
Debit Card Type: _____
Debit Card No.: _____
Security Code: _____
Expiration Date: _____
<input type="checkbox"/> Pay by Check Payable to Daniel Gaitan Personalized Healthcare, LLC

Payment

Annual Participation Fee (Payable on Application and Thirty (30) Days Prior to Renewal Date)
<input type="checkbox"/> \$2,200 per year for Primary Applicant
<input type="checkbox"/> \$2,000 per year for Secondary Applicant
<input type="checkbox"/> \$1,800 per year for each Tertiary Applicant
* Primary Applicant is responsible to pay for the Primary Applicant, the Secondary Applicant and each Tertiary Applicant.
Please initial boxes below:
<input type="checkbox"/> I have been provided with and understand the Terms and Conditions.
<input type="checkbox"/> I have been provided with and understand the Notice Privacy Practices.

Each of the undersigned Applicants applies to participate in the Personalized Services Program (the “Program”) offered by Daniel Gaitan Personalized Healthcare, LLC (“Program Sponsor”), as described in the Terms and Conditions of Personalized Services Program attached to this Application (the “Terms and Conditions”).

If an Applicant is accepted by Program Sponsor to participate in the Program (as signified by the signature of the Executive Director of the Program Sponsor at the end of this Application), the Applicant shall become a participant in the Program (a “Participant”), as outlined in the Terms and Conditions, and Applicant’s participation in the Program will be subject to and bound by and Applicant will comply with the Terms and Conditions.

In consideration of being accepted as a Participant in the Program, Applicant agrees to pay to Program Sponsor the amounts listed above at the times listed above in the manner listed above and if indicated above, authorizes Program Sponsor to credit/debit his/her credit card/debit card to pay such amount.

In consideration for such payment, Program Sponsor agrees to provide each Applicant with Personalized Services under the Program as described in this Application and subject to the Terms and Conditions (collectively, the “Agreement”).

[SIGNATURE PAGE FOLLOWS]

THIS CONTRACT CONTAINS AN ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

Primary Applicant Signature

Acceptance by Program Sponsor or Representative

Secondary Applicant Signature

By: _____
Melissa Frazier-Gaitan, MSN, APRN, FNP-BC,
Family Nurse Practitioner and Executive Director

Tertiary Applicant Signature
(if 18 years or older and under 26)

Date of Acceptance: _____
Address: 425 North New Ballas Road, Suite 107
St. Louis, MO 63141

ALL APPLICANTS MUST SIGN THE CONTRACT