

PATIENT ENROLLMENT FORM

The fees as set out in the attached Appendix C shall apply to the following Patient(s), who by signing below (or as the Patient's legal guardian), certify that they have read, are bound by, and agree to the terms and conditions of this Agreement.

Check YES where indicated only if you agree to text message communication. Provide an email address only if you agree to email communication.

Patient 1

Patient Name _____ Date of Birth _____

Street Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Email _____

Agree to Text Communication: (check one below)

☐ YES Cell Phone Number _____

☐ NO (check one)

Signature _____

Patient 2

Patient Name _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Email _____

Agree to Text Communication: (check one below)

☐ YES Cell Phone Number _____

☐ NO (check one)

Signature _____

MINORS TO WHOM THIS AGREEMENT APPLIES:

PRINT NAME _____

DATE OF BIRTH _____
MM DD YYYY

PRINT NAME _____

DATE OF BIRTH _____
MM DD YYYY

PRINT NAME _____

DATE OF BIRTH _____
MM DD YYYY

PRINT NAME _____

DATE OF BIRTH _____
MM DD YYYY

PARENT OR LEGAL GUARDIAN CONSENT:

I AGREE TO EMAIL COMMUNICATION IN REGARD TO THE ABOVE NAMED
MINORS (CHECK ONE BELOW)

☐ YES EMAIL ADDRESS: _____
☐ NO

I AGREE TO TEXT MESSAGE COMMUNICATION IN REGARD TO THE ABOVE-NAMED MINORS (CHECK ONE BELOW)

☐ YES MOBILE NUMBER: _____
☐ NO

SIGNATURE: _____

PRINTED NAME: _____ DATE: _____

REALTIONSHIP TO MINOR: _____