UNION
DIRECT PRIMARY CARE, LLC

Patient Enrollment Form

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the Union Direct Primary Care, LLC agreement form.

Printed Name		Date of Birth (MM/DD/YYY)	Age
Street Address		City State	Zip Code
Home Phone	Cell Phone	Preferred E-mail	
Spouse/SO name		Date of Birth (MM/DD/YYY)	Age
Home Phone	Cell Phone	Preferred E-mail	

Child/Children to Whom this Agreement Applies:

Print Name	Date of Birth (MM/DD/YYY)	Age
Print Name	Date of Birth (MM/DD/YYY)	Age
Print Name	Date of Birth (MM/DD/YYY)	Age
Print Name	Date of Birth (MM/DD/YYY)	Age

Preferred Payment Method

□ Yearly (Check or Credit/Debit Card) □ Monthly (Credit/Debit Card) □ Employer_____

I certify that I have read, understand, and agree to the terms set forth in the Union Direct Primary Care, LLC Agreement Form. I further certify that I have received a copy of this form.

Signature: _____

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