PATIENT ENROLLMENT AGREEMENT

Ally Direct Care
Rebecca Coats, MD
ph: (512) 468-4869 email: rcoatsmd@allydirectcare.com

PATIENT NAME DOB (mm/dd/yyyy) AGE

ADDRESS (street/city/state/zip)

CELL PHONE WORK PHONE EMAIL

GUARDIAN or PATIENT REPRESENTATIVE NAME DOB (mm/dd/yyyy) AGE

RELATIONSHIP TO PATIENT (parent, grandparent, child, partner, caregiver, etc.)

CELL PHONE (of guardian/representative) WORK PHONE EMAIL

PAYMENT AGREEMENT: You can choose to become a subscriber paying monthly, quarterly (every three months), half yearly (every 6 months) or yearly. Discounts apply for multi-month subscriptions, students and employees of enrolled businesses. Please refer to the ADC pricing list for details. Choose the frequency of payments below. By signing this form, I certify I have read, understand and agree to the terms set forth in this subscription agreement. I certify the information provided is true and correct to the best of my knowledge. A method of payment will be securely recorded here and used for subscriptions as agreed, until changes are made with the permission of the purchaser.

NAME ON CARD CARD NUMBER EXP DATE (mm/dd/yyyy) SECURITY CODE

☐ MONTHLY ☐ 3 MONTHS ☐ 6 MONTHS ☐ YEARLY

Printed name of responsible party Signature Date