

James J. Biemer, Jr., MD, FACP

9135 SW Barnes Rd, Suite 863, Portland, OR 97225
503-384-0316 phone 503-416-8145 fax

Enrollment Form

Rates:	Annual:	or	Monthly Payments:
Individual	\$720		\$60
Couple	\$1350		\$112.50
Additional family members (*college students waived while actively studying)	\$444		\$37

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

List Additional Patients Included in Program: _____

Select one of the following payment options:

___ **Monthly payments** may be paid **ONLY** by automatic credit/debit card withdrawal on either the 5th, 15th or 25th of every month.

**Please automatically debit my account for the amount of ___ on the 5th / 15th / 25th of each month

___ **Annual payment** may be made by cash, check or credit/debit card.

**Please bill me annually for the amount of ___

Credit /Debit Card Information (we accept Visa, MC, AMEX & Discover) for monthly payment, or to make initial annual payment.

Card Number: _____

Expiration Date: ____/____ CVV(3 digit code on back of card): _____

I understand that my annual fee pays for services outside of those typically covered by insurance. I understand that this fee is not a substitute for insurance. I understand that this annual fee does not cover or apply to my office care which is billed to my insurance, in accordance with a contractual agreement between insurer and Dr. Biemer. I understand that my concierge fee may not be used to cover co-pays, deductibles, or insurance balances. This agreement can be terminated by myself or Dr. Biemer at any time. Any unused portion of the annual concierge fee would be promptly refunded on a prorated basis if I decide to leave the practice.

Signature: _____ Date: _____

Office Use Only

Start Date	Program Type	Individual	Couple	Family	Amount Charged
Billing Interval	Comments				

