Darren D. Phelan, M.D.

**Membership and Membership Fee:**

Your membership runs from January 1st to December 31st each calendar year. Membership at other times of the year will prorate dues the following year.

| Total Care Fees: | | |
|---|---|---|
| *TCP* | $5,000 | **Individual / Couple** |
| | $9,000 | |
| *TCPF* | $12,000 | **Family** (2 adults + at home unmarried dependents <age 25, 24/7 access, cell phone access) |

**Credit Card Authorization**

Patient Name(s): _____

_____

Credit Card Holder's Name (as it appears on the credit card):

_____

Billing Address (must match the billing address of the credit card):

_____

_____

Credit Card Type (circle one): MasterCard Visa

Credit Card Number: _____

Exp. Date _____

3-digit security code (from back of card): _____

I hereby authorize the office of Darren D. Phelan, M.D. to charge this credit card for annual Practice Membership Fees. If paying by check, please write check number here. _____

Annual Fee _____

Signature of Card Holder and Date _____

**Please return to our office at the address listed below.**

**A copy of the agreement and receipt will be mailed to you at your request.**

*The fee is payable by check (preferred), Visa, or MasterCard. Membership fees are subject to change at the time of renewal.*

Your Personal Physician

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