



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* | \$4,500 | Individual / Couple |
| | \$8,000 | |
| *TCPF* | \$10,000 | 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