

Application
Sidney T. Robin, M.D.

This application applies to the following patients: Age: Cardio Program \$80/month

1. _____ _____ Yes _____ No _____

2. _____ _____ Yes _____ No _____

3. _____ _____ Yes _____ No _____

4. _____ _____ Yes _____ No _____

I agree to pay the annual fee as follows and understand that they will increase without notice as age changes.

Age	Monthly Fee	Fee with Discount for Bank Draft (paid at least quarterly)
50+	\$135/month	\$130/month
40-49	\$105/month	\$100/month
18-39	\$95/month	\$90/month
2-17	\$70/month	\$70/month
Student*	\$50/month	\$50/month
* <u>Student rate</u> : For those 25-years old and under attending school full time. Student must join with another adult member at the full membership price.		

Option 1: Please bill my credit card as follows:

VISA Mastercard

Annually Semi-Annually Quarterly Monthly

Name on card: _____ CVC Code: _____

Card Number: _____ Expires: _____

Responsible Party Name and Address (if different): _____

Authorized Signature: _____

Option 2: Please automatically deduct fee(s) from my checking account:

(Savings of \$60 per year for non-students 18 and over, if paid at least quarterly)

Annually Semi-Annually Quarterly Monthly

(Please attach a voided check with the application)

Name of Bank: _____

Name on Account: _____

Bank/Routing #: _____ Account #: _____

Authorized Signature: _____

*All fees paid in advance will be held in trust and released to Sidney T. Robin, M.D. On the 24th of each month for services provided during that month. Patients may leave Sidney T. Robin, M.D. at any time after six months and receive a refund of all fees held in trust that have not been earned as of that date. Unless other written arrangements are made, charges commence with the month during which this completed application is received and **continue until a written notice is received.***

Signature: _____ Date: _____

Office Use Only: Hint _____ Athena _____ Chart _____ Med Rec Req _____ Date _____