ATLAS MD

**Patient Enrollment**
**AtlasMD Concierge Family Practice**

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the AtlasMD Agreement Form.

Printed Name _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Street Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Preferred email _____

Spouse Name _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Home Phone _____ Work Phone _____ Cell Phone _____ Preferred email _____

***Child/Children to Whom this Agreement Applies:***

Print Name _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Print Name _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Print Name _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Print Name _____ Date of Birth (MM/DD/YYYY) _____ Age _____

## Preferred Payment Method

☐ Yearly (Check or Credit/Debit Card) ☐ Monthly (Credit/Debit Card) ☐ Employer_____

I certify that I have read, understand, and agree to the terms set forth in the AtlasMD Agreement Form. I further certify that I have received a copy of this form.

Signature: _____