MedNOW Advantage

Terms And Conditions *(Please Initial)*

_____ I acknowledge that I am joining the MedNOW Advantage membership program and I understand that the monthly membership fee will be automatically charged to my credit/debit card each month. I also understand that prices are subject to change with advance notice.

_____ I understand that this discount program cannot be used in conjunction with my private health insurance. It cannot be used with any U.S. Government insurance such as Medicaid or Medicare. By signing this for I agree that I do not have Medicaid or Medicare insurance. This discount program does not cover any durable medical equipment such as crutches, slings or braces. This discount program does not cover testing done outside the of MedNOW facility. Does not cover outside lab testing, such as bloodwork. Does not cover DME such as braces, slings or crutches. Does not cover Imaging studies such as CT, MRI or Ultrasounds.

_____ I authorize my credit/debit card to be charged for any additional services not paid for at the time of service. This would include any outside lab testing, Crutches, Slings or Braces that were not paid for at the time of service and are not covered under the MedNOW Advantage Program.

_____ I understand that I can cancel this agreement any time after the initial 6-month period. To cancel this membership, I must send an email to Billing@mednowurgentcare.com listing the names and DOB of members that wish to cancel the agreement. Request must be received 10 days before my next billing cycle. If this membership is cancelled before the completion of the 6-month period, you may be held responsible for the remaining amount. MedNOW reserves the right to cancel this membership for any reason and at any time before the next billing cycle.

Member Signature _____ Date _____

Staff Signature _____ Date _____

MedNOW Advantage

MedNOW Advantage is a medical discount program available for individuals and families who are seeking low cost office visits who do not have Medicare/Medicaid and have insurance plans with a high deductible. This discount program does not take the place of Medical insurance that the government requires that you carry. This discount is only available for the service rendered within the scope of our Urgent Care practice. This plan does not cover preventive medical services, treatment of chronic disease or work-related injuries and services.

Primary Member information - *Please Print Clearly*

Primary Member Name _____ D.O.B _____

Mailing address _____

City _____ State _____ Zip _____

Email _____ Phone _____

Additional Member Name _____ D.O.B _____

Additional Member Name _____ D.O.B _____

Additional Member Name _____ D.O.B _____

Additional Member Name _____ D.O.B _____

Payment Information

BY PROVIDING PAYMENT DETAILS YOU ARE AGREEING TO PARTICIPATE IN A MONTHLY MEMBERSHIP PROGRAM

Payer Name _____

Billing address _____ ☐ Same as above

Credit card# _____ Exp. Date _____ CVV _____

Credit Card information (please check one):

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Total Monthly charge: $ _____

Signature of card/account holder _____ Date _____