



## Arlington Pediatrics

### Direct Primary Care Membership Enrollment

Our Direct Primary Care Membership is designed to make your child's care simple and accessible. It offers clear monthly pricing, easy access to your pediatrician, and unlimited office visits.

#### Parent / Guardian Information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

#### Membership Plan Selection

Family Enrollment	Date of Enrollment	Name	DOB	Additional Comments
Child 1 (\$100/mo)				
Child 2 (+\$85/mo)				
Child 3 (+\$85/mo)				
Child 4 (Family Max*)				
Child 5 (Family Max*)				

*\*Family Max is \$270/mo*

#### Billing Frequency (Select One)

- Monthly automatic billing on date: \_\_\_\_\_
- Annual payment (paid in full)

#### Payment Method & Authorization

- Credit Card (Visa / MC / Discover / AmEx)

Card #: \_\_\_\_\_ Exp: \_\_\_\_/\_\_\_\_ CVV: \_\_\_\_\_

Billing Address (if different): \_\_\_\_\_

- Bank Draft (ACH)

Bank Name: \_\_\_\_\_

Routing #: \_\_\_\_\_

Account #: \_\_\_\_\_

Authorization for recurring charges per selected billing option. Initial: \_\_\_\_\_

## Membership Agreement & Statutory Disclosures (Texas)

This Agreement is a Direct Primary Care agreement recognized under Texas law. It is not health insurance, does not replace health insurance, and is not regulated as an insurance product.

Initials: \_\_\_\_\_

The membership fee covers routine primary care services only and is not based on the number of visits provided. Initials: \_\_\_\_\_

Arlington Pediatrics reserves the right to limit enrollment and may change services or fees with prior written notice. Either party may terminate this agreement with 30 days' written notice. If paid annually, refunds will be prorated for unused periods. Initials: \_\_\_\_\_

Services such as labs, imaging, vaccines, medications, and outside services are not included unless specifically stated. Cash-pay discounts may be offered at Arlington Pediatrics' discretion. Initials: \_\_\_\_\_

Direct physician access is not emergency care. In emergencies, call 911 or seek immediate medical attention. Initials: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_