Personalized PRIMARY CARE

Mark A. Lang, M.D.
9417 Broadview Road
Broadview Heights, OH 44147
Phone: (440) 545-2272 | Fax (440) 545-5645

Membership Registration - Page 1

Please complete information for each person included in your **Individual Membership** or **Family Membership**. A Family Membership is defined as spouses or spouses and their children. Children may be included in the Family Membership through their 26th birthday if they are on the family's health insurance. **Please complete both pages of this form.**

Your Name:_____

Home address _____ City _____ Zip _____

1) Last Name _____ First _____ Middle _____

Date of Birth _____ SSN _____ Email _____

Cell _____ Home Phone _____ Work Phone _____

Emergency Contact Name _____ Emergency Contact Number_____

2) Last Name _____ First _____ Middle _____

Date of Birth _____ SSN _____ Email _____

Cell _____ Home Phone _____ Work Phone _____

Emergency Contact Name _____ Emergency Contact Number_____

3) Last Name _____ First _____ Middle _____

Date of Birth _____ SSN _____ Email _____

Cell _____ Home Phone _____ Work Phone _____

Emergency Contact Name _____ Emergency Contact Number_____

4) Last Name _____ First _____ Middle _____

Date of Birth _____ SSN _____ Email _____

Cell _____ Home Phone _____ Work Phone _____

Emergency Contact Name _____ Emergency Contact Number_____

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Membership Registration – Page 2

Print Full Name: _____

Please indicate your preferred payment option by checking the appropriate box below and sign to confirm your selection of this annual membership. This membership fee applies to services rendered by Personalized Primary Care, LLC and is for services not covered by your medical insurance, including but not limited to: educational conferences, newsletters, and the bill managing services.

Individual Membership Payment Option	Family Membership Payment Option
☐ Single payment Option $948 ☐ Two payment Option $474	☐ Single payment Option $1797 ☐ Two payment Option $898.50 ☐ Three payment Option $599
Please sign below to accept this limited membership offer for an annual term with the above payment options for your convenience. Payments are due every 3 months until paid in full. Signature: _____ Date: _____	

All memberships are for a one year term with the first payment due at the start of services. Memberships are limited and will be accepted on a first-come first-serve basis. All returning members will have the first option to re-enroll. Personalized Primary Care, LLC reserves the right to defer membership for any enrollments or re-enrollments submitted without the initial payment.

First Payment Amount: _____

Total Amount Enclosed: _____

Please include your payment with this application. Checks should be made to: Personalized Primary Care, LLC., and mailed to: 9417 Broadview Road, Broadview Heights, Ohio 44147. **If using a debit or credit card, please complete the small slip of paper included so we can use the information and then destroy it. We do not want to hold your card information. Card transactions will be set to auto-pay at 3 month intervals until paid in full.**

Thank you for renewing with Personalized Primary Care, LLC.