

## CORNERSTONE MEDICAL PLAN CONTRACT

I authorize Cornerstone Medical Group to keep my signature on file and to charge my MasterCard, Visa or American Express account as indicated below.

MasterCard\_\_\_ Visa\_\_\_ American Express\_\_\_

Account number\_\_\_\_\_ Expiration Date\_\_\_\_\_

Name on card\_\_\_\_\_  
(Please print)

Signature\_\_\_\_\_

Recurring charges of \$\_\_\_\_\_ every month starting\_\_\_\_\_.

I agree to allow Cornerstone Medical Group to deduct monthly payments, copays and non-covered services from my credit card. I understand I can only receive services from participating Cornerstone Medical Group locations. I will also allow deductions from my credit card on patient balances, which go unpaid for a period of 60 days.

\*Membership only for \$50 per year\_\_\_\_\_  
(30% discount on our fee schedule)

Limited Urgent Services for \$23.33 per month\_\_\_\_\_  
\*\*(Includes 3 urgent visits per year)

Preventative Care for \$58.08 per month\_\_\_\_\_  
\*\*(Includes one physical exam and one office visit per year)

Chronic Conditions for \$65.92 per month\_\_\_\_\_  
\*\*(Includes three office visits and three urgent care visits per year)

*\*Paid in full before start date. No monthly deduction required.*

*\*\*Full descriptions of these plans included in the brochure and on the website at [www.cornerstonemedicalplan.com](http://www.cornerstonemedicalplan.com)*

My plan will start 7 days from the date this agreement is signed, and will be in effect for one year from that date. Services must be furnished within this one-year period.

**There will be no refunds given.**

Patient name\_\_\_\_\_

Parent Name\_\_\_\_\_  
(if patient is a minor)

Patient account number\_\_\_\_\_

\_\_\_\_\_  
(Participant's signature)

\_\_\_\_\_  
(Date)