MedNOW Cares

Terms and Conditions

Please review all lines below and then Initial each one

_____I acknowledge that I am joining the MedNOW Cares Discount Program and I understand that the monthly membership fee of $35 will be automatically charged to my card each month. I will be responsible for a $40 charge each time I visit a MedNOW office to be seen.

_____I understand that this discount program cannot be used in conjunction with my private medical insurance. By initialing this section, I am verifying that I do not have any government insurance such as Medicaid or Medicare.

_____I acknowledge that this discount program covers all services provided in office by MedNOW (x-rays, sutures, etc.) This program does NOT include any durable medical equipment (braces, crutches, or slings) outside imaging studies (CTs, MRI, Ultrasound) or Outside Lab work (Cultures or Blood Work).

_____I authorize my credit/debit card to be charged for any additional services not paid at time of service. This would be any service not covered by the discount plan mentioned above such as durable medical equipment or outside testing.

_____I understand that I can cancel this agreement at any time after the initial 6 month period is completed. To cancel this membership I must email discount@mednowurgentcare.com listing the names and date of births for members that wish to cancel. Request must be received 10 days prior to my next billing cycle. If membership is cancelled before completion of 6 month period, I may be held responsible for the remaining amount left before discount was applied. MedNOW reserves the right to cancel this membership for any reason at any time.

Member Signature_____ Date _____

Staff Signature_____ Date _____

MedNOW Cares Discount Program

Mednow Cares Discount Program is available for individuals who are seeking low costs office visits who do not have Medicare or Medicaid. This discount program does not take the place of medical insurance the government requires that you carry. This program is only available for the services rendered within the scope of our urgent care practices, and cannot be used for work related injuries or treatment of chronic diseases.

Member Information – Please Print Clearly

Member Name_____ DOB_____

Address_____

City_____ State_____ Zip_____

Email_____ Phone_____

Payment Date

_____ day of the month for all payments of $35.00 to be drafted from card provided below

The automatic deduction for your monthly MedNOW Cares Discount Program will be deducted from your account on the day provided. Please choose a day that is convenient for all monthly fees.

Credit/Debit Card Information

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number_____ Expiration Date _____/_____

Cardholder Name_____ Zip Code tied to Card_____

I the undersigned authorize and request MedNOW Urgent Care Center to charge my debit or credit card indicated above for program fees for the MedNOW Cares Discount Program. By providing payment information you are agreeing to participate in a monthly membership program and are financially responsible for a minimum of 6 months. This authorization will remain in effect until I cancel. To cancel I understand I must give a 10 day notification to MedNOW with my account being in good standing.

Patient Name (Print): _____

Patient/Guardian (Signature): _____Date_____/_____/_____