Enrollment and Annual Physician Payment Authorization Form

Please fill out the payment information below and mail the completed form to:

AllCare Medical Centers, P.C.
5860 Ranch Lake Blvd. Suite 200
Bradenton, FL 34202
Attn: Kelly L. Prather

PATIENT CERTIFICATION

I agree to pay the following Annual Physician Fee to Dr. Matthew Nessetti, M.D., Ph.D. For the following patients:

1._____ 2._____ 3._____

Annual Physician Fee: $2500.00 per person

1. PLEASE BILL MY CREDIT CARD:
   VISA MASTERCARD DISCOVER AMERICAN EXPRESS

   Name On Card: _____
   Card Number: _____
   Expiration Date:_____ CVV: _____

   Authorized Signature: _____ Date: _____
   Billing Address: _____

2. ENCLOSED IS A PERSONAL CHECK PAYABLE TO:
   ALLCARE MEDICAL CENTERS P.C.

PATIENT AGREEMENT

By my signature, I authorize AllCare Medical Centers, P.C. To charge the credit card indicated on this enrollment form and payment authorization form. This payment authorization is for the goods/services described in the Hybrid Concierge Outline for the amount indicated above only and is valid for one time use only. By my signature, I acknowledge that I have read, understand and agree to the terms of service in the Hybrid Concierge Model. I certify that I am a authorized user of this credit card and that I will not dispute the payment with my credit card company: so long as the transaction corresponds to the terms indicated on this form.

Patient Signature:_____ Date: _____