Mulberry Clinic
Spring Hill

REGISTRATION

PATIENT INFORMATION

First Name:	Last Name:		DOB:	☐Male ☐ Female
Home address:		City:	State:	Zip:
Billing address: ☐Same as home		City	State:	Zip:
Phone #1 ( )	☐ Home ☐ Work ☐ Cell		Phone #2 ( )	☐ Home ☐ Work ☐ Cell
Email address:				
Emergency Contact:		Phone: ( )		Relationship:

ADDITIONAL FAMILY MEMBERS ON MY ACCOUNT

First Name:	Last Name:	MI:	DOB:	☐ Under 26	☐ Female ☐ Male
Phone #: ( )	Email address:		Relationship to me:		
First Name:	Last Name	MI:	DOB:	☐ Under26	☐ Female ☐ Male
Phone #: ( )	Email address:		Relationship to me:		
First Name:	Last Name:	MI:	DOB:	☐ Under 26	☐ Female ☐ Male
Phone #: ( )	Email address:		Relationship to me:		
First Name:	Last Name:		DOB:	☐ Under 26	☐ Female ☐ Male
Phone #: ( )	Email address:		Relationship to me:		
First Name:	Last Name:	MI:	DOB:	☐ Under 26	☐ Female ☐ Male
Phone #: ( )	Email address:		Relationship to me:		
First Name:	Last Name:	MI:	DOB:	☐ Under 26	☐ Female ☐ Male
Phone #: ( )	Email address:		Relationship to me:		

BILLING

BILLING IS RECURRING AUTOMATICALLY ON A MONTHLY BASIS			
Credit or debit card #:	Expiration:	3 Digit Security #:	
Card Billing Address:	City:	State:	ZIP:
☐ Please add me to the billing account of an existing Mulberry Clinics patient associated with the above credit card			
Email Address:			

AUTHORIZATION

On behalf of all the members on this account, I understand and agree to the following (read and initial all items indicating your acceptance):

_____A one-time $99 registration fee per adult member will be included in my total initial charges

_____I will be charged a monthly recurring fee per adult member for primary' care services as described at MulberrvClinicspringhill.com

_____I will pay a $20 monthly recurring fee for each child under 26 years old on my account. If there is no adult on the account, then the first child will pay the regular adult monthly fee.

_____I may cancel at any time, but no refunds will be issued for the paid fees

_____If my membership lapses, I may re-apply at any time subject to a $99 re-registration fee; acceptance will be dependent upon availability of clinic space

_____I will pay a $25 fee for declined credit or debit card transactions

_____Prescriptions, certain vaccinations, medical supplies, and other items provided but not covered by my monthly service fee will be discussed with me in advance and automatically charged to my account's credit or debit card at the time such items are provided to me.

_____The transaction amounts charged will include my fees plus the fees incurred by all individuals listed above.

_____My participation is continuous and by signing below I authorize recurring debit/credit card charges.

_____My participation is voluntary and subject to the terms and conditions of membership detailed at MulberryClinicSpringHill.com

_____I understand that this agreement does not include comprehensive health insurance coverage nor is a contract of insurance

_____I understand specialty care, hospitalizations, surgery, third-party medical treatments, and other medical products and services not specifically provided by Mulberry Clinics are my sole responsibility and are not included or paid for by Mulberry Clinics.

SIGNATURE: _____ DATE: _____

PRINTNAME: _____ SIGNATURE BY: ☐ PATIENT ☐PARENT ☐ LEGAL GUARDIAN

Mail/drop off completed form to: Mulberry Clinics • 5328 Main Street, Suite K, Spring Hill, TN, 37174 615.614.2500