Lake Men's Health Center

Junior Membership Application

General Information

First Name: _____

Last Name: _____

Date of Birth: _____

Social Security Number: _____

Primary Phone: _____

- This is my: Home / Cell / Work *(please circle one)*

Alternate Phone: _____

- This is my: Home / Cell / Work *(please circle one)*

E-mail: _____

Street Address: _____

_____

City, State, Zip Code: _____

_____

T-shirt Size: _____

Primary Insurance: _____

Secondary Insurance: _____

Referral Source: _____

_____

Payment Options

The cost of the annual fee for the Lake Men's Health Center may be eligible for reimbursement through some HSA's, FSA's, or other similar health accounts. It is your responsibility to receive approval from your health insurance benefits coordinator as to the amount that may be reimbursable.

I elect to pay the annual fee as follows (please place a checkmark in the blank preceding the payment method you prefer):

Option 1

☐ **One lump sum of $1,000 payable as follows (select one):**

- ☐ My check is attached
- ☐ Charge my debit or credit card *(complete the card information below)*
- ☐ Invoice my employer for the lump sum annual fee:
  - **Employer Name:** _____
  - **Employer Contact:** _____
  - **Address:** _____

    _____
  - **Phone Number:** _____

Option 2

☐ **Twelve (12) equal monthly installments of $92 (total of $1,104) on the (choose one) ☐ 1st or ☐ 15th of each month.**

- **Please circle debit/credit card:** Visa / MasterCard / Discover / AmEx
- **Cardholder Name:** _____
- **Billing Address:** _____
- **Card Number:** _____

  _____
- **Security Code:** _____ **Expiration Date:** _____

I acknowledge receipt of a copy of the Membership Agreement, this Application, and the attached Required Comprehensive Disclosure Statement. By my signature below, I agree to the terms and conditions contained in the documents, including without limitation, the payment plan listed above. I further authorize Our Lady of the Lake Physician Group, L.L.C. to charge my debit/credit card in accordance with the payment schedule stated above.

Member's Signature: _____ **Date:** _____

Submit completed application to MHC@fmolhs.org or to fax to (225) 765-9462

Disclosure Statement >

Lake Men's Health Center

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Required Comprehensive Disclosure Statement

Direct Access Agreement Disclosures:
You should obtain and maintain insurance for services not provided under the Lake Men's Health Center membership agreement. The Practice will not bill a health insurance issuer for any services covered under the membership agreement. You are responsible for the payment of the fee specified in the membership agreement according to the payment terms set forth in the Agreement. Any services that are not specified in the Agreement shall be charged to you and/or your insurance company.

The contact information for the Louisiana State Board of Medicine is:

Louisiana State Board of Medical Examiners
A 630 Camp Street, New Orleans, LA 70130
T (504) 568-6820