62 Plus Care Program

Please complete the form below. All fields are required. Fax your completed form to (650) 566-9825, or mail it to 350 Cambridge Ave., Suite 250, Palo Alto, CA 94306 USA. Call (650) 566-9810 with any questions.

Demographic Information

First Name ______________________

Last Name: ______________________

E-Mail Address: ______________________

Phone: (   ) ______________________

Address: ______________________

City: ______________________

State: ____________ Zip Code: ____________

Age: ______ Gender: [ ] Female [ ] Male

Diabetes Type: [ ] Type 1 [ ] Type 2 [ ] Gestational [ ] Not Sure

Membership Type: [ ] Monthly ($416.70 USD) [ ] Annual ($5,000 USD)

How did you hear about us? ______________________

Payment Information

Payment Method (credit card only) [ ] Visa [ ] MasterCard [ ] Discover

Card Number (no spaces or dashes) ______________________

Name as it appears on your card: ______________________

Billing Zip Code: ____________ Expiration Date: Mo. ______ Yr. ______

[ ] I am currently a patient at Endocrine Metabolic Medical Center

I understand and agree to the following:

1. Endocrine Metabolic Medical Center does not provide emergency services. I will call 911 (or other emergency services) for appropriate help should I be in an emergency situation.
2. E-Mail is not a secure method of communication. I understand that there is a chance that e-mail communication could be intercepted, misdirected or otherwise tampered with by outside parties. I understand the risk of such violations to be extremely low.
3. Under this program the following services are provided: Unlimited office visits and unlimited procedures. Anything else will be Private Pay and I will be responsible.

Signed: ____

Name of Patient Date

A complete description of the program can be found at http://www.endocrinemetabolic.com