COASTAL PINES
MEDICAL GROUP

Membership Application

Coastal Pines Medical Group
2150 Main St, Suite #3
Cambria, Ca 93428

Membership Type:

- ☐ Individual: Monthly: $110 ***or*** Annual: $1,100
- ☐ Couples: Monthly: $200 ***or*** Annual: $2,200
- ☐ Family of 3: Monthly: $300 ***or*** Annual: $3,300

- ☐ Homebound: **(individual membership only)** Monthly: $200 ***or*** Annual: $2,400

Member Information:

_____ _____ _____ ____/____/____
Last Name **First Name** **M.I.** **Date of birth**

_____ _____
Address **Unit #**

_____ _____ _____
City **State** **Zip Code**

_____ _____
Home Phone **Mobile Phone**

_____
E-mail Address

Billing Information:(if not member) ▫N/A
Please complete this section if mail should be directed to a person other than Member, such as: Guardian, Conservator or person with Power of Attorney for member's healthcare decisions.
***** If you complete this section, all mail will be directed to this address.**

_____ _____ _____ ____/____/____
Last Name **First Name** **M.I.** **Date of birth**

_____ _____
Address **Unit #**

_____ _____ _____
City **State** **Zip Code**

_____ _____
Home Phone **Mobile Phone**

_____
E-mail Address

Credit Card Billing Information: ▫Check if same as Member Information ▫Check if same as Billing Information

_____ ____/____/____ _____
Card Number **Exp Date** **Security Code**
Type of Card:
▫ **Visa** ▫**Mastercard** ▫**Other:**_____

***If paying by Check, please make checks payable to: Coastal Pines Medical Group
Mail to: 2150 Main St, Suite #3 Cambria, CA 93428