Attachment 5: **Payment Information**

Member Information

Member Last Name:	Member First Name:	Date of Birth: ________/_______/______
Address:	City:	State: Zip Code:
Home Phone:	Mobile Phone:	Email Address:

Non-Member Billing Address [ ] N/A
Please complete this Section if mail should be directed to a person other than Member, such as a guardian, conservator, or person having power of attorney for Member's healthcare decisions ("Guardian"). If you complete this section, all mail will be directed to this address.

Last Name:	First Name:	
Address:	City:	State: Zip Code:
Home Phone:	Mobile Phone:	Email Address:

Credit Card Billing Information
□ Check if same as Member Information □ Check if same as Non-Member Billing Address Information

Type of card:
□ Visa □ M/C
Credit card number: Expiration: Security code:

If paying by check, please make checks payable to: Coastal Pines Medical Group.