

Membership Billing Application 2022+



Mail to: DIME Medical
 340 Main Street
 Darlington, WI 53530
 Fax to: (855) 574-5406
 Phone: (608) 482-2005

Primary Payor Member Name (for family): _____ Date: _____

I wish for Membership to be:

_____ ONE MONTH ONLY, then I understand that my membership will be suspended, and I may return in future but will have to repay the Enrollment fee to do so.

_____ Continuous Membership, Until I notify DIME Medical to suspend my membership.

_____ Other membership duration: _____

Payment Interval CHOOSE ONE:

_____ Every Month, _____ Every 12 months, _____ Every 6 months, _____ Every 3 mon

Discount PAYMENTS

Membership	12 months 5.0%	6 months 2.5%	3months 1.0%
Adult \$52.50/month	\$598.50	\$307.13	\$155.93
Child \$26.25/month	\$299.25	\$153.56	\$77.96
Family \$157.50+ (1) /month	\$1,795.50 + (1)	\$921.38+ (1)	\$467.78+ (1)

COST for FULL 12 MONTHS

Membership	12 months 5.0%	6 months 2.5%	3months 1.0%
Adult \$630/yr	\$598.50	\$614.25	\$623.70
Child \$315/yr	\$299.25	\$307.13	\$311.85
Family \$1,890+ (1) /yr	\$1,795.50+ (1)	\$1842.75+ (1)	\$1,871.10+ (1)

(1) Family = 2 Adults + 2 - 4 legal children + \$10.50 per additional child per month

ON the next page choose EITHER Automatic payments or Manual payments.

Automatic payments are then deducted from your Bank Account OR charged to your Credit Card.

Your bank account must be “verified” by you, reporting to us, of two small transactions from Atlas MD to your account, before we can begin deduction.

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1. AUTOMATIC PAYMENTS

Please choose date closest to Membership Start date

- Choose ONE:

On the ___ 1st, ___ 5th, ___ 10th, ___ 15th, ___ 20th, ___ 25th of the month

-Choose ONE:

Automatic Bank Deduction for membership fee and any charges:	___ Automatic / ___ Manual Credit Card payment of Membership fee and any charges:
Name of bank: _____	Name on Credit Card: _____
Account holder name: _____	_____
Routing Number: _____	Credit Card Number: _____
Bank Account Number: _____	CVC: _____
_____	Expiration Date: _____

2. Manually pay each payment period of membership fee & any charges:

Payment is due be BEFORE service period begins. 30 day grace period before membership is suspended if unpaid - waiver at discretion of DIME Medical.

___ Personal Check, ___ Cash, ___ Manual Credit Card payment only when individually authorized (enter info above card)

Please send me an invoice for the charges by: ___ Email, ___ Mail

Email account to use: _____

Address to use: _____

I authorize the direct bank deduction or Credit Card charge on the account listed in the preceding according to my choices, to pay the Membership Fee and any other fees/charges from DIME Medical:

Signature: _____ Date: _____