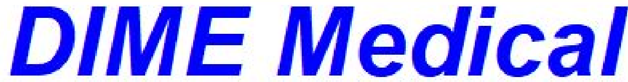
Membership Billing Application 2022+



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:__________

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

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Payment Interval CHOOSE ONE:

_____ Every Month, _____ Every 3 months, _____ Every 6 months, ____ Every year

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 monthly.

Your bank account must be “verfied” by your 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

- Chose 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:________________________________	Credit Card Number: ________________________________
Routing Number:______________________________	CVC: __________
Bank Account Number: _________________________________	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:_______________

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