Julie Reeves, M.D.
3637 Medina Rd., Ste. 220
Medina, OH 44256
Phone: (330) 764-7378 Fax: (330) 723-8357

Membership Registration – Page 1

Please complete information for each person included in your **Individual Membership** or **Family Membership**. A Family Membership is defined as spouses or parents and their children. Children may be included in the Family Membership through their 26th birthday if they are on the family's health insurance. **Please complete both sides. If no change to Page 1, check here** ❑

Home address_____ City_____ Zip_____

1) Last Name _____ First _____ Middle_____

Date of Birth _____ SSN_____ Email_____

Cell _____ Home Phone_____ Work Phone_____

Emergency Contact Name _____ Emergency Contact Number _____

Emergency Contact Relationship _____

2) Last Name _____ First _____ Middle_____

Date of Birth _____ SSN_____ Email_____

Cell _____ Home Phone_____ Work Phone_____

Emergency Contact Name _____ Emergency Contact Number _____

Emergency Contact Relationship _____

3) Last Name _____ First _____ Middle_____

Date of Birth _____ SSN_____ Email_____

Cell _____ Home Phone_____ Work Phone_____

4) Last Name _____ First _____ Middle_____

Date of Birth _____ SSN_____ Email_____

Cell _____ Home Phone_____ Work Phone_____

5) Last Name _____ First _____ Middle_____

Date of Birth _____ SSN_____ Email_____

Cell _____ Home Phone_____ Work Phone_____

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Membership Registration – Page 2

Print Full Name: _____

Please indicate your preferred payment option by checking the appropriate box below and sign to confirm your selection of this annual membership. This membership fee applies to services rendered by Family First Personalized Medicine, LLC, and is for services not covered by your medical insurance, including but not limited to: medical tests, e-newsletters, secure texts, and bill management services.

Individual Membership Payment Option	**Family Membership Payment Option**
☐ Single payment option $1500	☐ Single payment option $3000
☐ Two payment (biannual) option $800	☐ Two payment (biannual) option $1600
☐ Quarterly payment option $400	☐ Quarterly payment option $800
☐ Monthly payment option $135	☐ Monthly payment option $270

Please sign below to accept this limited membership offer for an annual term with the above payment options for your convenience.

Signature: _____ Date: _____

All memberships are for a one-year term with all payment options due **January 1, 2024** or at the start of services when applicable, with subsequent payments scheduled accordingly based on option selected. Memberships are limited and accepted on a first-come, first-serve basis. All returning members will have the first option to re-enroll. *Family First Personalized Medicine, LLC,* reserves the right to defer membership for any enrollments or re-enrollments submitted without the initial payment or balance on prior account.

Payment by: ❑ Check/Cash ❑ Credit/Debit Card or Bank Transfer/ACH via QuickBooks invoice*

**Invoices will be sent via email.*

Checks should be made to: ***Family First Personalized Medicine, LLC***
Please mail payment to: 3637 Medina Rd., Ste. 220, Medina, OH 44256

Thank you for joining Family First Personalized Medicine, LLC