



MCOR FITMED ENROLLMENT FORM

Subscriber name: _____ Date of Birth _____ Doctor _____
Address: _____ City _____ State ____ Zip code _____
Phone: _____

Based on your payment preference selected below, your FITMED Weight Management membership fee will **automatically** be charged following your program selection. Future follow up treatments will use the same payment method provided unless otherwise noted. If our Weight Management program is a FIT for you, this fee will be processed during enrollment.

This enrollment form will stay effective until one of the following occurs:

- You have completed the Weight Management Program
- Your credit card has expired –*new enrollment form would be completed*

_____ \$1,250.00 Weight/Wellness Management Program Primary Membership (*Initial Consultation with FitMed Health Coach and 12 weeks of monitoring*)

_____ Visa _____ MasterCard _____ Discover _____ Amex

Card number _____ exp date ____/____ security code _____

OR

Prefer Member Number: _____

Signature _____ Date _____

Program Start Date: _____