Payment Form

I have engaged Soundview Medical Group, PLLC and its physician, Lori A Cohen, MD to provide a personalized
Medical Care/Preventive Health program for a period of one year beginning
_____, 20__.

Please Choose Plan

____**Gold- $2000.00 annual or**

____**Gold -$189.00 per Month**

____**Gold-Spouse Plan-$3000 (must be paid in full)**

____**Silver- (Annual Comprehensive Exam)- $750**

METHOD OF PAYMENT: (Please choose one)

____Personal check enclosed. Please make check payable to Soundview Medical Group, PLLC

Mailing Address: Soundview Medical Group, PLLC
1000 Northern Blvd, Suite 175
Great Neck, NY 11021

____ Credit Card (Please circle one) MasterCard, Visa , American Express

I hereby authorize Soundview Medical Group, PLLC, to charge my credit card under the terms I have indicated above.

_____
Cardholder Signature

_____ _____ _____
Card Number Exp Date Security Code

Cardholder Billing Address:

If paying monthly by Credit Card your card will be charged at the beginning of the month.
If paying monthly by Check, an invoice will be sent and payment will be due by the 10th day of the month.
If payment is not received Soundview Medical Group, PLLC, has the right to terminate the agreement.
**Members on a Monthly Gold Plan , who receive the Comprehensive Exam and disenroll prior to the sixth month will be charged $750