Integrated Eye Care Collaborative, Inc.

Membership Dues Payment / Change Form

Please check the appropriate box:

☐ New Member ☐ Address Change ☐ Name Change ☐ Change in Amount

Doctor: _____
Last Name, Suffix First Name Middle Initial

Doctor: _____
Last Name, Suffix First Name Middle Initial

Doctor: _____
Last Name, Suffix First Name Middle Initial

Please attach a list of any additional doctors to be paid by this draft.

Contact: _____
Last Name, Suffix First Name Middle Initial

Telephone #: _____ email: _____

Check all that apply, please draft the following dues from my account:

☐ Basic Membership Dues $50 per Optometrist per year _____ (# of Doctors) X $50.00 = $_____ (Total)

☐ Basic Membership Dues $100 per Ophthalmologist per year _____ (# of Doctors) X $100.00 = $_____ (Total)

PLEASE SELECT ONE OF TWO PAYMENT OPTIONS Frequency: ☐ Monthly ☐ Quarterly ☐ Yearly

☐ **1. Credit/Debit Card #**: _____ Card Exp. Date: _____

Billing Address: _____ City, ST Zip _____

☐ **2. E-Check** (Please attach a voided check to assist in providing your bank information)

Type of Account: ☐ *Checking* ☐ *Savings*

Institution (Bank) Name: _____ *Your Bank Account #:* _____

Your Institution's 9-Digit Routing Number:* ____ ____ ____ ____ ____ ____ ____ ____ ____

*Your financial institution routing numbers are the first 9 digits in front of your account number on check.

Please check the appropriate box:

☐ I hereby authorize Integrated Eye Care Collaborative, Inc. to collect my dues as outlined above. I understand that failed payments may reduce my reimbursement conversion factor and jeopardize my membership.

☐ I hereby authorize Integrated Eye Care Collaborative, Inc. to make the necessary changes that I have indicated on this change form.

_____ _____
Authorized Signature / Title **Date**

The following page offers programs that allow you to recoup 100% of your dues.