# Pediatric Alternatives

## ENROLLMENT FORM

PARENT'S NAMES: ________________________________________ DATE: ______________

❑ I/we wish to enroll in **The Secret Garden** and be patients of Pediatric Alternatives.

***New patient one-time enrollment fee:* $900 covers one year from month of enrollment.**

If you have any questions about **The Secret Garden,** please call our staff for assistance at 415-380-8448.

Today's date ________________ Enclosed is my check for $ ____________________________

or charge my credit card: ❑ Visa ❑ MC ❑ Discover

Card No. ________________________________________ Expiration date ____________

Authorizing signature __________________________________________________________

***Optional Payment Plan:*** ❑ 3 monthly payments of $300 charged on the 15th of the month
❑ 6 monthly payments of $150 charged on the 25th of the month

*If you select a payment plan, we will process your credit card or post-dated checks once a month.*

Parent(s) name ________________________ Parent(s) name ________________________
Address ________________________ Address ________________________
City/State/Zip ________________________ City/State/Zip ________________________
Email ________________________ Email ________________________
Best/daytime phone (      )________________ Best/daytime phone (      )________________

First and last name of child M/F Birthdate First and last name of child M/F Birthdate
________________________/___ /________ ________________________/___ /________
________________________/___ /________ ________________________/___ /________

Delivery date ______________ Hospital ________________

Insurance Co. ____________________________ Subscriber ________________________

Subscriber's date of birth ________________ Social Security # ________________________

Subscriber's ID # ________________ Group # ____________________