HealthGAP
Medical Care You Can Afford
From Urgent Care of Omaha

Urgent Care
of Omaha

ENROLLMENT FORM

Bring this completed form in to any one of our two locations.

88th & Maple
8814 Maple St.
Omaha, NE 68134

168th & Maple
3830 N 167th Ct.
Omaha, NE 68116

★ Your Information:

Full Name:* _____

Address:* _____

State:* _____

Date of Birth:* _____

Address 2: _____

Zip:* _____

Phone:* _____

City:* _____

Email:* _____

**Required fields.*

★ Other Family Members' Information:

1) Full Name: _____

Relationship: _____

Date of Birth: _____

2) Full Name: _____

Relationship: _____

Date of Birth: _____

3) Full Name: _____

Relationship: _____

Date of Birth: _____

4) Full Name: _____

Relationship: _____

Date of Birth: _____

5) Full Name: _____

Relationship: _____

Date of Birth: _____

6) Full Name: _____

Relationship: _____

Date of Birth: _____

Payment information on next page.

★ Patient Agreement:

I have enrolled in Health Gap Membership – Urgent Care of Omaha, to be provided covered medical services for the period of ONE year, beginning on _____, and understand that a monthly fee is assessed for these services.

For Patient Membership During the Service Year, I Agree to Pay Health Gap Membership:

- ◯ **$50.00/month - Individual Membership**
- ◯ **$65.00/month - Two Person Membership**
- ◯ **$75.00/month - Family Membership** (up to 5 members total)
- ◯ _____**/month - Family Membership** (over 5 members total)

★ Method of Payment:

Credit Card / Debit Card _____ Visa _____MC _____Discover _____ Am Exp

I will pay monthly, automatically by reoccurring deduction from credit / debit card , each month, for 12 months & membership will automatically renew unless cancelled in writing (see terms & conditions – cancellation).

I authorize Health Gap Membership (MEDUSA, Urgent Care of Omaha) to automatically charge my credit/debit card the amount indicated above:

Cardholder Signature:_____

Card Number:_____

Expiration Date:_____ / Security Code:_____

Cardholder Billing Address:_____

City:_____ / State:____ / Zip:_____

Cardholder Telephone Number:_____