

# NEWPORT BEACH MEDICAL ASSOCIATES, INC.

PLEASE RETURN

1st Name \_\_\_\_\_

2nd Name \_\_\_\_\_

Children (ages 16-25) \_\_\_\_\_  
\_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

Individual  
\$2,000 per year

Two Adults  
\$4,000 per year

Family (two adults & children 16-25)  
\$4,400 per year

Yes, I would like to re-enroll in Dr. Berman's practice.

Enclosed is my annual check.

Please charge my  annual or  semi-annual fee to:

VISA  MASTERCARD

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have decided not to re-enroll in Dr. Berman's practice.

**James J. Berman, M.D.**

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