

ATEF E. KHOUZAM, M.D., F.A.C.P.
NEWPORT BEACH MEDICAL ASSOCIATES, INC.

Please return with signed contract.

Patient's Name _____

Spouse's Name _____

Children's Name _____

Address _____

City/State _____

Zip Code _____ Phone _____

Individual \$2,000 per year

Family (couples with children age 17-25) \$4,500 per year

Yes, enroll me in Dr. Khouzam's concierge practice.

Enclosed is my annual check.

Please charge my VISA MASTERCARD

Card Number _____

Expiration Date ____ / ____

Name on Card _____

Signature _____ Date _____

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