

**Kern Augustine Conroy & Schoppmann, P.C.**  
**1120 Route 22 East**  
**Bridgewater, NJ 08807**

**Physician Advocacy Plan**  
**APPLICATION**

Name: \_\_\_\_\_

Name of Practice \_\_\_\_\_

Address of Practice: \_\_\_\_\_

\_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_ Group Provider #: \_\_\_\_\_

**Individual Membership:**  
(Check One)

- Basic Program - \$175  
 Comprehensive Program - \$525

**Comprehensive Group Rate:**

- 3 Physician Group - \$1,450  
4 or more - # Physicians x \$195  
+ Group rate of \$1,000

Names of Physicians and other Health Care Providers (Attach additional sheet if required):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***I have read the Program Description and Agree to its terms.***

Enclosed is my check for \$ \_\_\_\_\_

Credit Card: Visa \_\_\_ MasterCard \_\_\_ American Express \_\_\_

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Authorized Amount \$ \_\_\_\_\_

By signing this application I hereby authorize Kern Augustine Conroy & Schoppmann, P.C. to charge my credit card for the authorized amount stated above. I understand that the charge will appear on my credit card statement as "Kern Augustine"