THE RESTORATIVE NEUROLOGY CLINIC AT BURKE
MEMBERSHIP AGREEMENT - ROBOTICS

NAME_____ **DATE OF BIRTH** ____/____/_____

ADDRESS _____ **PHONE** _____

CITY _____ **STATE** _____ **ZIP** _____

EMAIL _____ **WOULD YOU LIKE TO RECEIVE EMAILS? □ YES □ NO**

EMERGENCY CONTACT_____ **PHONE**_____

STAFF USE ONLY – ENROLLMENT DATE: _____/_____/_____

MEMBERSHIP OPTIONS – CHOOSE ONE

Total Fee - $5400

☐ PAID IN FULL Check #_____ Cash _____ Credit Card _____

☐ 2 Payments $2700.00 each, 1 payment billed prior to program start; Final payment billed week 2
Payment 1 - Check #_____ Cash _____ Credit Card _____
Payment 2 - Check #_____ Cash _____ Credit Card _____

☐ 7 Payments $2700 billed prior to program start - Check #_____ Cash _____ Credit Card _____
$450 billed to credit card per week for 6 weeks

PURCHASER'S RIGHT TO CANCEL: IF YOU WISH TO CANCEL THIS AGREEMENT, YOU MAY CANCEL BY MAILING A WRITTEN NOTICE TO THE BURKE MEDICAL RESEARCH INSTITUTE. THE NOTICE MUST SAY THAT YOU DO NOT WISH TO BE BOUND BY THIS AGREEMENT AND MUST BE MAILED BY MIDNIGHT OF THE THIRD BUSINESS DAY AFTER YOU SIGN THE AGREEMENT. After you cancel, The Burke Medical Research Institute may request the return of all agreements, membership cards and other documents of evidence of membership. The notice must be delivered or sent by certified mail to: The Burke Medical Research Institute, 785 Mamaroneck Ave., White Plains, NY 10605. If the member becomes deceased, no lien will be attached to your estate and a prorated share of the unused portion of the membership will be refunded to the estate.

_____ _____
Buyer/Member Signature Date

CREDIT CARD BILLING

□MASTERCARD □VISA □AMEX CARD # _____
EXP. DATE _____/_____

CARD ISSUER _____ **NAME ON CARD** _____

1ST Payment - $ _____ **□ Paid in Full Signature**_____

Remaining Balance_____ **To be paid as indicated above. Signature** _____