CFR ELITE REGISTRATION FORM

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CELL PHONE: _____ **WK PHONE:** _____

E-MAIL: _____

Welcome to "The CFR Doctors Elite". Members of this Elite Group are entitled to special privileges, discounts, and recognition, including:

- ✓ A special "Elite Doctor" listing on the CFR website
- ✓ A one-third discount on all future CFR Advanced Seminars
- ✓ NO Charge for CE credits *on ALL future seminars* - Basic & Advanced
- ✓ FREE Annual CFR Replacement Kits once a year, which includes 2 new bulbs, a bag of inflator cots, a box of rolled-up cover finger cots, a bag of rubber bands, and colloidal silver gel
- ✓ Automatic updates on all new CFR forms sent in editable word document formats
- ✓ A 50 pack of CFR tri-fold patient pamphlets
- ✓ A FREE CFR T-shirt and CFR Mug

The cost of membership is only $75/mo. auto debit and runs in 12 month blocks OR you may pay an Annual Fee of $795 and save $105 for paying all at once. To become a member, please complete the following:

PAYMENT METHOD _____VISA _____MC _____AMEX _____DISCOVER

CREDIT CARD NO. _____

EXP _____ **CVC** _____ **Billing Zip Code** _____

A 3.5% Service Charge Will Be Added to Registration to Cover Credit Card Processing Fees.

I, _____, hereby authorize *Dr. Adam Del Torto*, to initiate debits/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment of services/products rendered to me in the amount of $ _____ OR Balance Due, not to exceed $ _____ per transaction/month. The authorization is to remain in effect for 12 months, and may be withdrawn by me, by written request only after initial 12 month period has ended.

If you choose to cancel your automatic payment(s), or changes need to be made to the account being charged, please contact Dr. Adam J. Del Torto, 139 Fenway Dr. Sagle, ID. 83860 (818) 427.1312. This authorization will remain in effect until you provide written notice revoking the authorization at least 10 days before your account is to be debited/charged. Notice may be mailed to the above.

SIGNATURE _____ **DATE** _____

Return completed form to:
dr.adamrocks@gmail.com
T: (818) 427-1312
Thank you!