

**Your life is digital.
Your bill can be, too.**

Go Paperless



Name _____ DOB _____ Male Female

Mailing Address _____

City, State, Zip _____ Home Phone _____

Cell Phone _____ Work Phone _____

Email _____

I the undersigned hereby authorize Associated Physicians Group to send paperless statements to the above email address. By signing this, I understand that I will no longer receive paper statements in the mail. It is my responsibility to contact APG to advise of any change to my contact information, including my active email, that may impede me receiving these statements. This shall remain in effect until revoked by me in writing or through email contact.

SIGNATURE

DATE

