PO Box 15, Afton, VA 22920
Phone 540-932-3100
Fax 540-932-3101

EZ-Pay Account Debit Program Participation Form for 2024

PLEASE CHECK: ☐ **New Enrollment** **OR** ☐ **Change(s) to Existing Enrollment**

Unified VCA Membership Information

Name: _____ Practice/Co.:_____

Street: _____ City, State, Zip: _____

Phone: _____ Fax: _____

E-mail (VCA business only): _____

Cell:_____ May we text you with relevant UVCA information? ___Yes ___No

CHECK APPLICABLE MEMBERSHIP CATEGORY FOR 2024:

	Quarterly	Yearly		Quarterly	Yearly
___ Student	n/a	$ 35	___ DC Spouse	50% of 1st DC's rate	50% of 1st DC's rate
___ 1st year in VA practice	$ 42.50	$ 170	___ Out of State DC	$ 30.00	$120
___ 2nd year in VA practice	$ 90.00	$ 360	___ Retired DC	$ 15.50	$ 62
___ 3rd year in VA practice	$132.50	$ 530	___ Allied Supplier	$137.50	$550
___ 4th year or more	$162.50	$ 650	___ Supplier/DC Combo	$187.50	$750
___ Premier DC Upgrade	$375.00	$1500			

OR just $125 per month (monthly option available for Premier DCs only)

Payment Information (EZ-Pay Account Debit Program)

☐ **Checking** ☐ Quarterly ☐ Monthly (Monthly Option for Premier DCs Only)

Bank Name: _____ Acct. Type: ☐ Business ☐ Personal

Acct. #:_____ ABA Routing #:___ ___ ___ ___ ___ ___ ___ ___ ___ [Enclose a voided check]

☐ **Credit Card** ☐ Quarterly ☐ Monthly (Premier DC Only) ☐ Visa ☐ MC ☐ Discover ☐ AmEx

Acct. #:_____ Exp.:_____

3-4 Digit Security Code: _____ Name on Card: _____

Billing Address: _____

"I authorize the VCA to debit my checking or credit card account as indicated above. I acknowledge the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. Said debits shall occur on or about the 1st day of the appropriate membership period for the amount of my monthly, quarterly or annual dues payments. Amounts will be adjusted by VCA if I change my VCA membership category, any applied discount expires, or rate changes. I understand this authority is to remain in full force and effect until the VCA has received written notification from me of its termination in such time and manner as to afford the VCA a reasonable opportunity to act on it."

Your Signature: _____ Date: _____

☐ Please use this payment information for my **Virginia C-PAC** contribution, as well. The UVCA will forward to C-PAC on your behalf. (For information about C-PAC, go to www.virginiachiropractic.org and click on the Legislative tab.)
☐ I give Virginia C-PAC permission to send C-PAC information to me.

Simply fax the requested information to the Unified VCA office at 540-932-3101, or mail to UVCA, PO Box 15, Afton, VA 22920
Questions? Call 540-932-3100 or email melissaluce.vca@gmail.com. Thank you!

Updated 3/5/2024 ml