Dedicated Private Practice Physicians

IPHA Membership Application

Quality Experience
Quality Care
Clear Prices
Independent Physicians

Indiana Physicians Health Alliance

NAME / ADDRESS OF PRACTICE

JOIN ☐ **RENEW** ☐

Date

- **SMALL PRACTICE MEMBERSHIP: 1-5 PHYSICIANS**..... **Annual Fee : $200.00 per physician**
- **MID SIZE PRACTICE MEMBERSHIP: 6-10 PHYSICIANS**..... **Annual Fee : $1750.00 per year**
- **LARGE PRACTICE MEMBERSHIP: 11+ PHYSICIANS**..... **Annual Fee : $2500.00 per year**

Member Contact Information :

First Name

Last Name

Address

Zip Code

Phone No

E-Mail

Practice Specialty

Total Number of Physicians in Practice/Group

Please List Practice Physicians' Names and Specialties (or attach to this application)

Name	Specialty

Does your practice require physicians to be board certified:

Yes ☐ No ☐

I attest that this information is true, accurate and complete, and that the ownership of the practice submitting this application is a truly independent physician practice with 100% physician ownership.

Dated:

Signature

Committee Interest:

Advocacy Membership Technology

Please email a high resolution image of the practice logo to Cindy@IPHA.health

Please connect with IPHA on LinkedIn