TEXAS OPIOID TREATMENT ALLIANCE
MEMBERSHIP FORM

Organization Name: ____

Address: ____

Phone #:____________________ Fax #:____________________

Email address: ___________________________

Number of Clinics in Organization: ___________

Total Number of Patients: ________________

Annual Fee Amount: $_________

TOTA Provider Representative: _________________________

I, ____________________________________ have read information explaining TOTA and I am willing to adhere to its bylaws and its ethical cannon as well as all financial, membership and grievance policies and procedures.

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Signature of Provider Representative Date

Return this form along with payment to:

Texas Opioid Treatment Alliance, Inc.
Attn: Membership
PO Box 35418
Houston, Texas 77235
Fax- 713-283-1222
Office- 281-501-2293

Fee Schedule

Patients	***Fee***
Less than 100	No Charge
101-150	$100
151-200	$200
201-250	$300
251-300	$400
300+	$500