Clear Lake Internal Medicine Enrollment Form

Name:_____DOB_____

How do you prefer to be addressed? _____

Phone (Home): _____ Phone (Cell): _____

Email optional):_____

Address: _____ City: _____ Zip: _____

PLEASE SELECT ONE OF FOLLOWING PAYMENT OPTIONS:

_____ Enclosed is a check for the total annual fee. Please debit this account to pay the fees each year at time of annual contract renewal.

_____ Please automatically debit my checking account monthly for the fee.

_____ Please charge my debit/credit card account for the total annual fee.

_____ Please charge my debit/credit card account for the monthly fee.

Patient Signature: _____ Date: _____

*Please provide **either** Credit Card or Bank Draft Information unless annual fee paid in full by check.*

Credit Card Information:____ MasterCard ____ Visa

Card Number: _____CVV Code:_____Exp Date: _____

Name on Card: _____Payment Amount: _____

Billing Address: _____

City: _____ Zip: _____

Card Holder Signature: _____ Date: _____

ACH Bank Draft Account Information:

Name on Account:_____

Name of Bank and Bank Address (Please attach a voided check):

_____

Bank Routing Number _____Account Number _____

Please complete this form and mail along with any payment to: Clear Lake Internal Medicine 2020 Nasa Parkway #290 Nassau Bay TX 77058 Fax: 281-335-7598