Patient Enrollment Form

Please complete this form, sign below and return it to the following address:

Esper Concierge and Sleep Medicine, PA
5959 West Loop South suite #510
Bellaire, TX 77401
If paying by credit card you can choose to email it to info@EsperMedicine.com or fax it to **(832)409-5965**

Once we receive this form, a spot will be reserved for you and we will email you the Patient Membership Agreement. The spot will be released if we do not receive the signed Patient Membership Agreement and payment within 15 days from the time the email is sent. If paying by credit card, please provide the credit card information below. If paying by check, please make the check payable to **Esper Concierge and Sleep Medicine, PA**.

Membership Level: (Please check the options that apply)

___Individual Membership: ___ $1,800 annually or ___$475 quarterly

___Couple Membership: ___ $3,400 annually or ___$900 quarterly

___Adult Child (age 26-39) whose parent is a member:

___ $1,200 annually or ___ $325 quarterly

Member's Name: _____ DOB: _____

E-Mail: _____

Second Member's Name: _____ DOB: _____

E-Mail: _____

Address: _____ city: _____State: Zip code:

Home Phone: _____ Cell Phone: _____

If you are an adult child (age 26 - 39) whose parent is a member, please provide the following information:

Parent's Name: _____ DOB: _____

Dependent children (age 18 - 25) of a member may be included for no additional charge.

The children to be included are:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Credit Card Info:

Type of Card: _____ Card Number: _____ Expiration Date: _____

Name on Card: _____ Security Code: _____
Signature _____ Date: