

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: ___ \$3,000 annually or ___ \$775 quarterly

___ Couple Membership: ___ \$5,600 annually or ___ \$1,450 quarterly

Member's Name: _____ DOB: _____

E-Mail: _____

Second Member's Name: _____ DOB: _____

E-Mail: _____

Address: _____

city: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Credit Card Info:

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

Name on Card: _____ Security Code: _____

Signature _____

Date: _____