BROWDER CLINIC RESPONSE FORM

Name: _____ Date of Birth: _____

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

Address: _____ City: _____ Zip: _____

Names and ages of family members to join:_____

_____

PLEASE SELECT ONE OR MORE FROM THE FOLLOWING OPTIONS:

_____ Please enroll me and my family members listed as new patients of Browder Clinic.

_____ I have enclosed a check for our initial total annual fees. Please debit this account to pay the annual fees each year at time of annual contract renewal.

_____ Please debit my checking account for the monthly fees every month. (Enclose a voided check please.)

_____ Please charge my debit/credit card account for our total annual fees.

_____ Please charge my debit/credit card account for the monthly fees every month.

_____ Please have your nurse contact me to answer my questions.

Patient Signature: _____ Date: _____

Credit/Debit Card Information: ____ Credit Card _____ Debit Card

____ MasterCard ____ Visa ____ American Express ____ Discover

Card Number: _____ Expiration Date: _____

Name on Card: _____ Total Payment: _____

Billing Address: _____ City: _____ Zip: _____

Card Holder Signature: _____ Date: _____

Please complete this form and fax or mail along with any payment to:
BROWDER CLINIC, PLLC
7005 WOODWAY DRIVE, SUITE 201, WACO, TEXAS 76712
Phone: 254.732.3633 Fax 254.732.3661