DEBORAH A. SUTCLIFFE, MD

MODERN MEDICINE, OLD FASHIONED CARING

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the Agreement Form.

Printed Name/Head of Household DOB Age

Street Address City State Zip

Primary Phone (Cell?) Work Phone Cell Email

Spouse Name DOB Age

Primary Phone (cell?) Work Phone Cell Email

Child/Children to Whom this Agreement Applies:

Name DOB Age

Name DOB Age

Name DOB Age

Name DOB Age

Preferred Payment Method: □ Yearly (Check or Credit/Debit Card) □ Monthly (Credit/Debit Card)/ACH □ Employer_____

I certify that I have read, understand, and agree to the terms set forth in the Agreement Form. I further certify that I have received a copy of this form.

Signature: _____

345 HICKORY STREET, RED BLUFF, CA 96080 (530) 529-4190