Cascade Direct Care Enrollment

Patient Information

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Male Female

Email: _____ Phone: _____

Billing

Option #1: Automatic Funds Transfer

Name on Account: _____

Bank Name: _____

Account Type: Checking Savings Account Number: _____

Bank Routing Number: *Please attach voided check*

Option #2: Credit/Debit Card

Name on Account: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Type: Visa Mastercard

Credit Card Number: _____

Expiration Date: _____ 3-Digit Security Code (*from back of card*): _____