MedCHOICE FINANCIAL

Program Enrollment Form

Please Complete this form an fax it back to: **1-800-490-2292**
If you have any questions please call: 1-800-865-7020 USA
(011-52) 664 900-7122 MEXICO

MRP MEDICAL RESOURCE PARTNERS
An Authorized MedChoice Provider

Doctor Name	Practice Name	Years in Practice

Practice Address	City

State	Zip	Phone	Fax

Medical License #	State	Federal Tax ID# or SSN	Key Financing Contact

Board Certif cations	Other Practice Locations?	Would you like to enroll the other locations?
	Yes ☐ No ☐	Yes ☐ No ☐

Program Selection (Please select the program(s) you would like to enroll in)

☐ 0% **Physician Discount**
Choices Card - Reg. Revolving Line of Credit

Promotional Programs: 3, 6 & 12 Mo **Deferred Interest and Deferred Payments**

☐ Yes, I am interested in offering these promotional programs. (discounts may apply)

I certify that information above is accurate and current and I have read and agree to the MedChoice Provider Agreement. I wish to enroll my practice in the MedChoice Financial Patient Financing Program.

Physician / Office Administrator _____ Please Print Name _____ Date _____

Funding Method: (please select one) ☐ ACH ☐ Check

ACH Information

I hereby authorize MedChoice Financial LLC, its partners tranferees and assigns to automatically deposit any funds owed to me through the MedChoice Choices Credit Card Program to my checking account at the f nancial institution listed below.

Routing Number _____ **Account Number** _____

IMPORTANT: Please also supply us with a copy of a Voided Check from this account.

Financial Institution _____

I hereby certify that the above information is accurate and complete and I agree with provisions discussed above.

Authorized Signature _____ **Print Name** _____ **Date** _____

Credit Card Processing

As an enrolled provider of MedChoice Financial you are entitled to deep discounts with MedChoice Financial's credit card processing program. This program **will** save you money from your current program and we invite you to f nd out how much.

☐ **YES**, please have someone contact us regarding this program ☐ No Thanks

MedCHOICE FINANCIAL

Please Mail Originals to:

Usa and Mexico Patient Financing
P.O. Box 28928
Santa Ana, CA 92799

Please Complete this form an FAX it back to: **1-949-872-2720**

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