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## Employer Agreement for Direct Care Services at Hitchcock Family Medicine

Business Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Who Should Receive Monthly Invoices (please include all names and email addresses if different from primary business contact.

\_\_\_\_\_

Date for Membership to Start: \_\_\_\_\_

Number of Enrollees at Start: \_\_\_\_\_

Future Enrollees may Start: \_\_\_ Immediately when they enroll \_\_\_ On the 1<sup>st</sup> of the next month

**We will pay the following percentages of fees for our employees:**

Employee Membership Fee: 100% Other: \_\_\_\_\_

Labs: \_\_\_\_\_ Imaging: \_\_\_\_\_ Medications: \_\_\_\_\_ Procedures: \_\_\_\_\_

**We will pay the following percentages of fees for our employees' family members:**

We will pay for up to this many family members: \_\_\_\_\_

Family Membership Fee: 100% Other: \_\_\_\_\_

Labs: \_\_\_\_\_ Imaging: \_\_\_\_\_ Medications: \_\_\_\_\_ Procedures: \_\_\_\_\_

Please bill us on the: 5<sup>th</sup> 10<sup>th</sup> 15<sup>th</sup> 20<sup>th</sup> via Credit Card ACH

For ACH Billing: (Preferred)

Account Holder Name: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

\*Please note you will receive two small deposits into your account. Please email us with the date and amounts of these two deposits so we can verify your account. Billing through ACH will not be enabled until this verification process is complete.

For Credit/Debit Card Billing:

Name on Card: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Card Number: \_\_\_\_\_ Security Code: \_\_\_\_\_

Name (print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_