

# AGREEMENT

NAME OF PRACTICE: \_\_\_\_\_

TYPE OF PRACTICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WEB ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_

CONTACT EMAIL: \_\_\_\_\_

- Number of procedures performed yearly: \_\_\_\_\_
- Average dollar amount of procedures: \_\_\_\_\_
- Percent of procedures self-paid/financed: \_\_\_\_\_
- Current finance institution: \_\_\_\_\_
- Do you have a finance/payment person on staff? YES / NO  
If yes, please provide contact name, email and phone number:  
\_\_\_\_\_
- Are you currently e-marketing? YES / NO  
Would you like to? YES / NO
- Do you request direct electronic deposit of funds? YES / NO  
If yes, please provide account information:
  - Name on account: \_\_\_\_\_
  - Account number: \_\_\_\_\_
  - Name of bank: \_\_\_\_\_
  - Bank routing number: \_\_\_\_\_
- Will you enroll in our Split-Pay program enabling you to take your fee independent of hospital centers payment? YES / NO

This is to certify that \_\_\_\_\_ agrees to become an agent of New Image Credit, LLC (NIC), and to present NIC as a payment option to patients.

We agree to the administrative fee of \$ \_\_\_\_\_ to partner with NIC.

SIGNED BY \_\_\_\_\_ DATE \_\_\_\_\_

TITLE \_\_\_\_\_