



Facility Membership Agreement

Membership Agreement Date: _____ **Assigned Member#:** _____
[For In-office Use Only]

THIS MEMBERSHIP AGREEMENT ('AGREEMENT') is for
"Payment Protection" Services and is between:

Paycare MEDICAL Program / ADRC (Parent Company)
5605 Hilltop Rd.
Jamestown, North Carolina 27282
P: 336.897.3008 F: 336.852.8333

and

Clinic/Facility Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

herein after, called the "The Parties." The Parties agree to respect the integrity and tangible value of this Agreement between them.

THIS AGREEMENT is for a term of one (1) year(s) and annually renews from the date of execution and is to be applied to any and all transactions present and future, throughout the 1-year, renewable contract period.

Membership Type:

Paycare MEDICAL (\$ Paid Direct to clinic) _____

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5605 Hilltop Rd, Jamestown, NC 27282

P: 336.553.1670 F: 336.852.8333 E: info@paycareprogram.org



Facility Membership Agreement

Whereas, _____ facility agrees to the following Paycare PLUS Program fee schedule for this individual facility site:

- \$300.00 Paycare Mbrshp** [1st YearwRq'd with 1stPay Incentive] _____ (initials)
- \$1700.00 Annual Mbrshp** [auto-renew or 30-day written notice] _____ (initials)
- 10% Past Parent Fees [withheld from recovered fees] _____ (initials)
- 10% Current Parent Fees [withheld from Pay incentives] _____ (initials)
- Free** "Parent's Promise" Plan input _____ (initials)
- Free** Membership Window Decal _____ (initials)

Services and Fees Schedule List:

*Up-front \$300 membership deposit avoids a separate annual Set-Up Fee

- R'qd Paycare Yr-2 Membership** (\$300 Per Year, Per Site; **Not out-of-pocket**)
- Pay Incentives paid directly to your facility** (\$1700 Mbrshp/Site; **Not out-of-pocket**)
- Parents' past unpaid fees paid to your Clinic (10% of amount returned; Not out-of-pocket)
- Parents' current Pay incentives paid to your facility (10% of Pay incentives; Not out-of-pocket)
- Membership Window Decal **Free**
- "Parent's Promise Plan" input **Free**; Clinic expectations from parents
- STARTER 'Pay incentives' Paid to Facility in monthly payments

As agreed above, No up-front payment is required in the intial membership year. **Paycare MEDICAL** Membeshiip begins upon receipt of facility-member's signed Membership Agreement, State/Business License and company 'voided' check or debit card copy. The fee of **(\$300.00, (Three-Hundred)** dollars, due upon processing the facility-members' 1st 'Pay Incentive' via account draft.

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Paycare MEDICAL will be paid via “hold-back” (50% held out of Pay incentives sent to your facility, credited to pay the annual Paycare MEDICAL membership fee) and **not out-of-pocket**.

Once we receive this Agreement and the **required**, up-front membership deposit per site, our office will then assign your facility’s Membership number, Set Up your account and your facility may begin receiving Pay incentives on behalf of parents, for their child(ren).

Paycare MEDICAL Program values confidentiality and commits to keep all member records and submissions confidential and secure. The Parties agree to keep confidential any Paycare MEDICAL Program processes, the information of all contacts introduced or revealed to the other Party. Information will solely be used for the purposes of this Agreement. No other use is allowable unless agreed in writing by both Parties.

The Parties will construe THIS AGREEMENT in accordance with the laws of the State of **(North Carolina)**, County of **(Guilford)**. Any disagreement shall be settled by mediation between the two Parties. If any provision of this agreement is found to be void during mediation, the remaining provisions will remain in force and effect.

Any suspected or tracked abuse will result in revoked membership and forfeit of fees previously paid.

THIS AGREEMENT contains the entire understanding between the Parties and any waiver, amendment or modification to THIS AGREEMENT will be subject to the above conditions and must be attached hereto. Both Parties may give a 30-day written cancellation notice prior to the anniversary, automatic-renewal date.

A facsimile copy of this Agreement shall constitute a legal and binding instrument. By setting forth my hand below I warrant that I have complete authority to enter into THIS AGREEMENT:

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Facility Membership Agreement

Authorized Clinic/Facility Signature

Date

Authorized Clinic/Facility Printed Name

Authorized Paycare Medical Program Signature

Date

Authorized Paycare Medical Program Printed Name

Paycare MEDICAL Membership Section:

*You may have completed this form online; However, we must have your signed membership agreement.

Facility Name: _____

Facility Address: _____

Facility Contact: _____ Facility Ph#: _____

Contact Title: _____ Facility Fx#: _____

Facility website: _____

Facility Type: ____ Medical/Clinic ____ Health/Rehab ____ Dentist ____ Other



Facility Membership Agreement

Any additional facilities you want to join Paycare MEDICAL (\$300 deposit each):

Facility Name: _____

Facility Address: _____

Facility Contact: _____ Facility Ph#: _____

Contact Title: _____ Facility Fx#: _____

Facility Type: _____ Medical/Clinic _____ Health/Rehab _____ Dentist _____ Other

**separate membership numbers will be provided for additional facilities*

New-Member Instructions:

- Step #1: Return the enclosed Paycare MEDICAL Membership Agreement (with 'void' check/debit card copy and State License copy)
- Step #2: To Request a 'Pay incentive':
www.paycareprogram.org; Click 'Refer a Parent Pay Incentive' tab (enter information)
- Step #3: Provide input for "Parent's Promise" Plans; Call and/or Complete and sign the Parent Referral Slip to Refer Parents you currently work with who need assistance paying fees to your clinic/facility.
- Step #4: To Report **Parents** who have **not paid your facility in the past**:
www.paycareprogram.org; Click 'Members' tab; Click 'Submit Unpaid Pmts' tab (enter the information)
Our office will contact parents you've submitted into our 'Submit Unpaid Pmts' tab; We will partner with them have the payment processed to pay your facility; You never pay out-of-pocket as we simply process the past-due payment to you, minus a 10% fee.
- Step #5: To Obtain a Line of Credit **OR** "OAN" 15-day funding for your facility, Call our office.

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Facility Membership Agreement

PAYCARE MEDICAL PARENT REFERRAL SLIP

Clinic/Facility Name: _____

Doctor/Principal Name: _____

Clinic/Facility Address: _____

Clinic/Facility Phone#: _____ Email: _____

Mr(s). _____ is requesting a Pay incentive

In the amount of \$ _____; Reason/Purpose: _____

Parent's Phone#: _____

For the benefit of:

_____ (Child's Full Name)

_____ (Child's Date of Birth)

Our Facility understands while Pay incentives are to be paid up-front for Parents, 'Starter' Program Pay incentives will be paid in monthly payments

AUTHORIZED FACILITY SIGNATURE: _____ Date: _____

Title: _____

I do understand that this Pay incentive will be made for me once my membership is established; My information is verified; And I review, agree to and sign my "Parent's Promise" Plan. My associated fees will be paid via electronic draft from my checking account, according to my "Parent's Promise" Plan.

I agree to submit a complete membership application, picture ID copy, most recent paystub and bank statement (all pages), and copy of a 'void' check/debit card for information verification by Paycare MEDICAL Program.

Parent's Signature: _____ **Date:** _____

*Fax to: 336.852.8333 Email to: info@paycareprogram.org

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