This form is editable. Fill out, print, sign & return.

MEDISOL PLUS

CREDIT APPLICATION – MEDICAL OFFICE

COMPANY INFORMATION

Legal Entity Name: _____ DBA: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ DUNS: _____

Tax ID/EIN: _____ Tax Exemption: ☐ Yes ☐ No *(If yes, please send a copy of your tax exemption certificate)*

Ownership: ☐ Sole Proprietor ☐ Corporation Years in Business: _____

Owner Name: _____ Cell: _____ Email: _____

A/P Manager: _____ Cell: _____ Email: _____

PRACTICE INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Office Manager: _____ State Board License: _____

Phone: _____ Email: _____

HCP INFORMATION *(Provide separate sheet for practices over 6 providers)*

Provider 1: _____ NPI: _____ ☐ MD ☐ NP ☐ PA

Provider 2: _____ NPI: _____ ☐ MD ☐ NP ☐ PA

Provider 3: _____ NPI: _____ ☐ MD ☐ NP ☐ PA

Provider 4: _____ NPI: _____ ☐ MD ☐ NP ☐ PA

Provider 5: _____ NPI: _____ ☐ MD ☐ NP ☐ PA

Provider 6: _____ NPI: _____ ☐ MD ☐ NP ☐ PA

PAYMENT INFORMATION

☐ **ACH Draft** *(Please send a copy of voided check)*

Bank Name: _____

Address: _____

Routing #: _____ Account #: _____

Contact Name: _____ Phone: _____

☐ **CARD** **Card Type: ☐ Credit ☐ Debit**

Name as it appears on Card: _____

Card #: _____ Exp: _____

CVV: _____ Zip Code: _____

Guarantee and Payment Authorization Signature Page to Follow

Guarantor and Payment Authorization Signature Page

I, _____ personally guarantee all payments of existing and future obligations and unconditionally waive the right to any amount pursuant to this provision. The undersigned also agrees to jurisdiction and venue in Texas. The above statements are made of purpose of procuring credit from Medisol Plus, LLC. The undersigned hereby consents to the confirmation by company, of the information contained herein and authorizes company to contact the undersigned's bank for ACH transactions. If "Credit Card" is checked as form of payment on the form above, the undersigned guarantor or authorized officer of the credit card reflected above does hereby authorize Medisol Plus, LLC to change the credit card for the charges indicated.

Terms of the sale have been fully explained and I understand that if an account is established, my credit line is subject to periodic review. For Accounts with ACH elected as the payment option, shipments may be held if my account is delinquent due to NSF or returned payment. The undersigned further represents that its professional licenses are in good standing and not the subject of any proceedings by any government agency and agrees to notify the seller immediately upon the commencement of any such proceedings. The undersigned authorizes company to take appropriate measures in verifying the credit of the undersigned and releases company from any obligation while researching this information. Customer and guarantor agree to provide company with 60 days' intention to sell all of its assets. Special contract pricing is subject to verification of entitlement at any time after the sale and customer agrees to refund in the event there is no entitlement.

Medisol Plus, LLC, its division and affiliates, may from time to time, provide promotional information via phone, fax or email to its customers. You may request to remove from any of their channels by contacting Medisol Plus, LLC by email, fax or phone. The federal equal credit opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status; age; (provide the applicant has the capacity to enter into a binding contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercise any right under the consumer credit protection act.

Guarantor Name: _____

Signature of Guarantor: _____ Date: _____

Please provide copies of the following along with Credit Application:

- State Board License
- DEA License
- Sales Tax Exemption Certificate (*If applicable*)
- Voided Check (*If ACH form of payment is selected*)

Return Credit Application Via:
Email: info@medisolplus.com
Fax: (469) 914-0019