Corporate Enrollment Form

Company Name:____

Company Contact/Title: ____

Additional Contact/Title **(Person to receive invoice):** _________________________________

Address: ____

City: ______________________ **State:** __________________ **Zip Code:** ______________

Phone Number: ____

Email: ____

Coverage (employer responsibility to Flex Family Health DPC)

Membership: ___________%

Labs: ___________%

Misc Charges (procedures, medications.) ___________%

Preferred Payment Method:

- **Monthly Check** **(will be invoiced on the first of each month, due on the 15th of each month)**

- **Monthly Credit Card/ACH**
  - **Circle desired monthly auto- payment date: 1st or 15th** **(of each month)**

As noted by my signature below, as an authorized representative of the above named company, I understand that:

1. **I am voluntarily electing to provide membership services, in part or in whole, to employees of my company.**

2. **It is my responsibility as the employer, to notify Flex Family Health as soon as possible when there are changes to memberships/enrollments- including but not limited to initial enrollments, terminations, and new enrollments.**
    a. **Flex Family Health has the absolute power and right to accept or decline patients.**
3. **It is my responsibility to accurately convey and represent the terms of this agreement, to those affected by this agreement.**
4. **I agree to pay the above agreed upon coverage fees due on the same date each month to Flex Family Health.**
    a. **If I elect to have my employees pay a portion, and the employee fails to pay their portion by the agreed upon due date each month, their membership will be terminated and your company will no longer be charged on their behalf.**
5. **Flex Family Health membership(s) are not health insurance policy.**

Company Representative Printed Name: ___________________________________

Company Representative Signature: _______________________________________

Title: ____

Date:___________________________

Effective date of Agreement: ____

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Flex Family Health