FLEX family health
DIRECT PRIMARY CARE

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BILLINGS, MT 59102
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# Corporate Enrollment Form

**Company Name:** _____

**Company Contact/Title:** _____

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

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Phone Number:** _____ **Email (s):** _____

**PLEASE INDICATE WHETHER EMPLOYER WILL ALSO BE RESPONSIBLE FOR THE FOLLOWING:**

| | NO | YES | IF YES- % EMPLOYER WILL COVER |
|---|---|---|---|
| LABS | | | |
| MISC. CHARGES (PROCEDURES, MEDICATIONS, ETC.) | | | |

**INDICATE 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 Auto-Payment**
*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 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 (i.e. my employees and their covered spouses/dependents).**

**4. I agree to pay the full amount due for monthly membership fees, and any percentage of labs and/or miscellaneous charges, for those covered under my company's agreement, each month, to Flex Family Health based on the agreed upon terms as indicated by me on this form.**

**a. If any individual covered under my company's agreement incurs charges for which payment responsibility is the individual's (not the company's), and the individual 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 a health insurance policy.**

**Company Representative Printed Name: _____**

**Company Representative Signature: _____**

**Title: _____**

**Date: _____**