



NW PIONEER

Employer Agreement

Employer Agreement for Direct Care Services at NW Pioneer DPC

Business Name: _____

Contact Name: _____

Contact Phone: _____ Email: _____

Date for Membership to Begin: _____

Family members covered: Yes No (List members included on enrollment form)

Number enrollees ages 0-18: _____ x \$29

Number enrollees ages 19-29: _____ x \$39

Number enrollees ages 30+: _____ x \$69

Number of family plan enrolled (2 Adults, 2 children): _____ x \$175

Total monthly membership fee: \$_____

We will pay the following percentages of fees for our employees:

Employee Membership Fee: 100% or other (specify) _____%

Payment by check, automatic bank withdrawal, or visa/MasterCard of the first month's membership fee is due on the first date of service. Please return this enrollment form along with your authorization for ongoing automatic monthly payments. Please make checks payable to: NW Pioneer DPC, PLLC.



Automatic Payment Authorization

- Monthly membership fees will be automatically transferred to NW Pioneer DPC, PLLC each month on the same day of the month that my membership was accepted by NW Pioneer DPC (or as soon as practical thereafter) as payment for services for that month's billing cycle.
- I understand that this Authorization will remain in effect until NW Pioneer DPC has received written notice from me of cancellation. Membership is month to month. I have the right to stop payment of a specific transfer at least five (5) business days before the next scheduled withdrawal.
- I understand and authorize that a \$25 fee will be charged to me for non-sufficient funds or any event preventing payment to NW Pioneer DPC, PLLC.
- I understand that the standard recurring transaction amount is the total of all authorized and enrolled employees as listed above.

Authorization for automatic payment of recurring monthly fee:

Total monthly membership fee for all employees enrolled: \$ _____

Credit or Debit Card information:

Name on Card: _____

Card Billing Address: _____

Card Type: Visa MasterCard AMEX Discover Exp. Date: _____

Card Number: _____

3 or 4 Digit Security Code: _____

OR

Banking Account: Voided check attached.

Bank: _____

Name on Account: _____

Routing Number: _____

Account Number: _____

I understand and will comply with the above payment terms. I hereby authorize NW Pioneer DPC, PLLC, to initiate credit/debit card transactions or automatic bank withdrawals on a monthly basis for the above total monthly fee. I authorize my financial institution to honor these transfers.

Authorized Signature: _____ Date: _____

Name of Authorized agent: _____

E-mail address: _____ Phone number: _____



EMPLOYER NAME: _____

ENROLLEES:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:

Employee Name: _____ DOB: _____

Phone number: _____ Email: _____

Family Members Authorized:
