



Doctor Enrollment Agreement

(Fax this form to CSI at 254-772-4642 to enroll your practice with DOCPAY™)

Practice Name: _____ Phone: _____
Practice Address: _____ Fax: _____

Email: _____

Contact: _____
Bank Name: _____
Name on Account: _____
Routing Number: _____
Account Number: _____

I, _____ authorize Complete Systems, Inc. (CSI) to print and deposit pre-authorized checks against my account for services rendered as follows:

What CSI will do: For each signed Patient Authorization form received from practice by CSI, CSI will establish a Pre-Authorized Checks Payment Plan and deliver to the above referenced address, multiple drafts for a specified amount each for the specified duration of the authorization. Doctor may at his own choosing charge patient as little or as much as he desires as a convenience fee. Regardless of the fee collected by doctor, CSI will draft the above referenced account \$19.95 per Payment plan established.

How you pay us: Each month, an invoice will be faxed or mailed listing the Payment Plans established in the prior month and the practice bank account will be drafted one week later for \$19.95 times the number of plans established in the prior month.

Your responsibility: I also agree and understand that I am contracting with CSI solely for the printing and delivery of pre-authorized check drafts drawn on my patients' accounts. I understand that it is my responsibility to securely store the checks and deposit them according to the terms of my patients' authorization.

Authorized Signer for Referenced Account

Date

Attach Copy of \$49.95 Check From Practice Here