

Preferred Provider Agreement, TWL

Once Completed, please scan/fax/email this form along with attachments to This Whole Life Foundation

Name of Business: _____

Business Address: _____

Phone: _____ Email: _____ Website: _____

Services offered at place of business: Standard Service Rate: Discount Rate/Written off Amt:

****If there are more services/rate provided, please list on a separate page and attach to this document.****

As a preferred provider for wellness services with This Whole Life Foundation (TWL) I agree to bill This Whole Life for services instead of the client for services rendered. I agree to bill TWL for agreed upon service discount rates written above. _____ (initial)

As a preferred provider for wellness services with TWL I agree to only provide the amount of sessions as stated in client scholarship agreement (Client will bring client receipt of scholarship in hand to first appointment and agreement will state how many appointments this client is allowed to receive from scholarship) and **no more** unless more scholarship funds have been determined to be distributed to the client by This Whole Life Foundation. _____ (initial)

As a preferred provider I agree to abide by agreed upon service rates listed above. I agree that this contract may be terminated by either party at anytime with a 30 day notice for client reassignment. _____ (initial)

As a preferred provider for wellness services with TWL I agree to place advertising for This Whole Life at my place of business to help promote others to donate, to give supplies, or for others to know where to apply for scholarship services. _____ (initial)

As a preferred provider for wellness services with This Whole Life Foundation (TWL) I agree to provide these clients with the utmost in quality care for services rendered. _____ (initial)

As a preferred provider of wellness services, I agree to communicate with This Whole Life Foundation should there be a need for a client to receive more services than originally provided. I agree to work with This Whole Life Foundation to find appropriate referral sources for clients if need be. _____ (initial)

As a preferred provider of wellness services, I agree to attach a copy of my certificates/licenses, as well as attach a copy of my proof of liability insurances. _____ (initial)

Preferred Provider License Type(if applicable): _____ License Number: _____

License/Certificate Effectiveness Dates: (from) _____ (to) _____

Business Representative Name Printed: _____

Representative Signature: _____

Date Acknowledged: _____

TWL Foundation Representative: _____ Signature: _____