

Preferred Provider Agreement



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
(must be at least 25% discount for services costing less than \$200):

_____	_____	_____
_____	_____	_____
_____	_____	_____

If there are more services/rates 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 receipt (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)

In order to help our faith based organizations know if you are a provider that we should refer clients to based on your faith and it's alignment with the values of the Christian Church - please initial this statement if you so align. **If you do not align - please leave blank:** "As a preferred provider I agree that my values align with This Whole Life Foundation and I support the TWLF statement of faith. The This Whole Life Statement of Faith is as follows: "We believe in the centrality of Jesus Christ. His crucifixion, his resurrection, and his life in us as believers."

_____ (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: _____