HEALTHCARE PROVIDER
SET UP REQUEST FORM

PAYRIGHT

HEALTHCARE PROVIDER OFFICE INFORMATION

Provider Name

MID

Mailing Address

City

State

Zip Code

Contact Name

E-Mail Address

Phone

REFERRAL PARTNER INFORMATION

Referral Partner Office Name

Partner No.

Contact Name

E-Mail Address

Phone

SET UP PREFERENCES + RELATED FEES (CHECK ALL THAT APPLY)

PAYMENT MANAGER (VT)
Accept Payments at Front-Desk or Back-Office

MONTHLY FEE

PAYMENT OPTIONS ALLOWED

◯ **Card** ☐ *Swiped* ☐ *Manual*

◯ **ACH** ☐ *Mail* ☐ *Phone* ☐ *Web*

◯ **Cash**

◯ **Check**

◯ **Payment Plans/Recurring Billing**

◯ **Invoices** *(E-Mail or Text)*

ORDER OPTIONAL CARD READER

◯ Yes ◯ No

MX™ ePAY
Patient-Facing Online Bill Payment Portal

MONTHLY FEE

LOGO PROVIDED ◯ Yes ◯ No

SITE URL

CONVENIENCE FEE ◯ Yes ◯ No

CREDIT Percent % *or* Per Item $

DEBIT Percent % *or* Per Item $

MAKE/MODEL

MX™ PAYMENT SYNC
Syncs Payments with a Locally-installed EHR

MONTHLY FEE

EHR NAME

EHR VERSION NO.

NO. OF WORKSTATIONS

Please submit a completed Equipment Order Form to:
support@payrighthealth.com

By signing below you authorize PayRight Health Solutions, LLC and its affiliate Priority Payment Systems, LLC to transfer/debit funds to/from the designation checking associated with your merchant services account. Furthermore you acknowledge that you have read, understand, and agree to comply with the terms and fees set forth in both this authorization form and the terms of service available for review or download from http://payrighthealth.com/static/termsofservice.pdf

Merchant Signature

Title

Date