

When faced with the challenge of helping people change their lives, providing affordable payment options should be the least of your concerns.

Clark Behavioral Health Financing is designed to help you connect your clients with the best and most comprehensive financing choices on the market. Our compassionate and professional team is dedicated to personally helping people from the first call to the closing of their loan. Since 2003, programs through out the United States have entrusted us to find solutions for their clients. We are pleased to introduce a new choice.

MedChoice, a loan product specifically designed for the treatment industry, is fast, affordable and funds quickly to the facility. Clark Behavioral Health Financing is exclusively offering this product to treatment centers who meet the criteria. Below is an overview of this product and instructions to the attached application. If you have any additional questions after reviewing this form, please feel free to contact us.

Borrower Benefits*

FAST AND EASY

- ✓ Quick Application
- ✓ Immediate Answers
- ✓ Funding in 48 hours
- ✓ Borrow up to \$30K
- ✓ Low Monthly Payments
- ✓ Confidential, Professional Customer Service

*Borrowers must meet credit criteria. All customers will receive a free credit review and loan consultation.

Facility Benefits

INCREASE CASH FLOW FAST

- ✓ Low Monthly Payments for Your Clients
- ✓ Quick Decisioning
- ✓ Very Easy Application
- ✓ Extremely Fast Funding by ACH
- ✓ No Up Front Fees or Sign Up Cost
- ✓ World Class Customer Service for You and Your Clients

Facility Requirements:

1. Licensed Physician on Staff
2. ACH Information/Voiced Check
3. Select Payment Program* (multiple programs can be selected).

Payment Programs- This is the only plan that offers NO Payment Promotions for 3, 6 or 12 months! This allows your staff to help more clients into your facility. Clark Financing will gladly offer one or all of the repayment options to your clients. The choice is yours.

Standard Repayment

Receive .92 cents for every dollar borrowed
Client begins repayment immediately

3 Month Deferred Interest

Receive .91 cents for every dollar borrowed
\$3000 min. must be repaid in 3 months or interest will accrue retroactively.

6 Month Deferred Interest

Receive 89.6 cents for every dollar borrowed
\$3000 min. must be repaid in 6 months or interest will accrue retroactively.

12 Month Deferred Interest

Receive 84.5 cents for every dollar borrowed
\$3000 min. must be repaid in 12 months or interest will accrue retroactively.

*Eligible programs must agree to a facility service fee. This fee **is not** paid out of pocket, but is deducted from the proceeds of the loan funds.

Please Complete this form and fax to: **208.676.1702**
 If you have any questions please call: **888.755.3079**

PROGRAM ENROLLMENT FORM

Facility Name		Physician on Staff Name		Medical License Number
Facility Address		City	State	Zip Code
Facility License Number	Phone		Fax	
Provider Number	Federal Tax ID Number or SSN		Key Office Contact Name	
Email Address			Key Office Contact Number	

Program Selection: Please select the program(s) you would like to enroll in.*

- | | |
|--|--|
| <input type="checkbox"/> Standard Regular Revolving: 7.9% (facility service fee)
(\$1 minimum purchase) | <input type="checkbox"/> 3 Month Deferred Interest: 8.9% (facility service fee)
(\$3,000 minimum purchase) |
| <input type="checkbox"/> 6 Month Deferred Interest: 10.4% (facility service fee)
(\$3,000 minimum purchase) | <input type="checkbox"/> 12 Month Deferred Interest: 15.51% (facility service fee)
(\$1,000 minimum purchase) |

I wish to enroll my facility in the MedChoice Financial Program. I certify that the information above is accurate and I have read and agree to the MedChoice Provider Agreement.

 Authorized Signature

 Please Print Name

 Date

Funding Method: ACH (initiated within 48 hours)

ACH Information

I hereby authorize MedChoice Financial LLC, its partners transferees and assigns to automatically deposit any funds owed to me through the MedChoice Choices Credit Card Program to my checking account at the financial institution listed below.

_____ Routing Number	_____ Account Number
_____ Financial Institution	IMPORTANT: Please also supply us with a copy of a Voided Check from this account.

I hereby certify that the above information is accurate and complete and I agree with provisions discussed above.

 Authorized Signature

 Print Name

 Date

IF YOU HAVE ANY QUESTIONS PLEASE CALL: 888.755.3079

*Service fee is a MedChoice charge to facility, not a consumer charge.