MEDICAL

Base Setup **Authorization Form**

LOCATION OR PRACTICE INFORMATION

LOCATION OR PRACTICE NAME	LOCATION PHONE #	#OF LOCATIONS

LOCATION OR PRACTICE ADDRESS	CITY	STATE	ZIP

PRIMARY CONTACT NAME	CONTACT PHONE #	CONTACT EMAIL ADDRESS

ADMIN USER INFORMATION[1]

ADMIN USER NAME	ADMIN USER PHONE #	ADMIN USER EMAIL ADDRESS

MX MEDICAL BASE PAYMENT ACCEPTANCE OPTIONS[2]

IN OFFICE / POS ONLY ☐ ONLINE BILL PAY ONLY ☐ BOTH POS & ONLINE BILL PAY ☐

PAYMENT ACCEPTANCE TYPE (CHECK ALL THAT APPLY) [3]

CREDIT ☐ DEBIT ☐ CASH (POS ONLY) ☐ ACH/ECHECK ☐

MERCHANT FEE AUTHORIZATION & TERMS ACKNOWLEDGMENT

INITIAL SETUP FEE	MONTHLY SERVICE FEE	TRANSACTION FEE (PER ITEM PROCESSED)

By signing below, you authorize Priority Payment Systems to transfer/debit funds to/from the designated 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 setup authorization form and the Payright Health Solutions, LLC Terms of Service, which are available for review or download at: http://payrighthealth.com/static/termsofservice.pdf

MERCHANT SIGNATURE	TITLE	DATE

FOR AGENT/ISO OFFICE USE

AGENT/ISO OFFICE NAME	AGENT/ISO PHONE NUMBER

SALES REP NAME	SALES REP PHONE NUMBER

SALES REP EMAIL ADDRESS	
FOR PRIORITY USE ONLY	
MERCHANT ID	EMAIL SET-UP REQUEST TO PRODUCTSALES@PPS.IO

[1] User responsible for location administration and assigning other users
[2] Setup and configuration preferences
[3] Additional set up fees apply for ACH acceptance. Fees for card payments are billed via the monthly Merchant Statement; for all other forms of payment, fees are direct billed monthly to the merchant's designated clearing account via ACH.