NIHC Credentialing Application

Please read, complete, and sign this form in the space provided. If additional space is needed, attach a separate sheet. Your written authorization is required as a condition of your employment

Print Doctor Name:

_____

(First) (Middle) (Last)

Former Name (Alias) and Dates Used: _____

Home Address Since:_____

(Last 5 Years) (Mo/Yr) (Street)

_____

(City) (Zip/State)

Practice Address Since: _____

(Last 5 Years) (Mo/Yr) (Street)

_____

(City) (Zip/State)

Telephone #: _____ EMAIL :_____

DL #: _____ DOB :_____

Medical Lic #: _____ SSN#: _____

Are you an existing DC at The Joint? **YES/NO** Are you a newly hired DC at The Joint? **YES/NO**

A Current copy of Malpractice declaration page must be attached along with their license.

I hereby authorized NIHC Group to investigate my background and qualifications for purposes of evaluating whether I am qualified for the position of Doctor of Chiropractic. I understand that NIHC Group may utilize an outside firm or firms to assist it in checking such information, and I specifically authorize such an investigation to include, but not limited , the following areas: verification of social security number; credit reports; current and previous residences; current and previous employment history; education background; professional license; malpractice claims; character references; drug testing; civil and criminal history records from any jurisdiction(s); driving records; birth records; and any other public or industry records.

The information contained in this authorization is correct to the best of my knowledge.

_____ _____

DC Provider Signature Date

PRIMARY CLINIC:

Name of the Provider:_____

Clinic Main Contact and Phone:_____

Clinic Name:_____

Physical Address:_____

Practice Mailing Address:_____

Franchisee Name:_____

Physical Address:_____

Phone: _____ Fax: _____

E-Mail: _____

Include:
• Copy of license of each doctor
• Copy of malpractice Certificate of Insurance for each doctor

ADDITIONAL CLINIC:

Clinic Name:_____

Physical Address:_____

Clinic Mailing Address: _____

Franchisee Name:_____

Physical Address:_____

Phone: _____ Fax: _____

E-Mail: _____

Include:
• Copy of license of each doctor
• Copy of malpractice Certificate of Insurance for each doctor

NIHC Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Practice/Franchisee Name: _____

Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ CVV: _____

Billing Street Address: _____

Billing City & State: _____

Billing Zip Code: _____

I, _____, authorize National Integrated HealthCare Group LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

The above charge(s) will appear on your statement as NIHC Credentialing.

Authorization: I agree that this is a timely charge that will be processed as indicated above (if applicable). I hereby agree and acknowledge that I will not dispute NIHC Group recurring billing with my credit card issuer. I guarantee and warrant that I am the legal cardholder for this credit card, and that I am legally authorized to enter into this recurring billing agreement with NIHC Group. In the event the credit card expires, or any charges are denied, I do hereby agree to provide NIHC Group with a new and valid card within 48 hours of expiration or denial. I further authorize a $35.00 service charge for denied, cancelled or terminated payments not in accordance with this Agreement.

Recurring Billing: I hereby acknowledge that there will be no advance notice of billing and authorize National Integrated HealthCare Group (NIHC Group) to process recurring payments (if applicable for malpractice renewal verification, license renewal verification etc.). If the DC separates from my practice, I will notify NIHC immediately. This authorization will remain in effect until cancelled.