Healthcare Networks of America
RESTORING PHYSICIAN PROSPERITY

Enrollment Form

Provider's Name: _____ NPI #:

Title: MD DO DC DPM Other: ___ Directory Specialty: ___

Address: _____

City: _____ State: Zip Code: ____

Federal Tax ID Number: _____ Phone: _____

Dr.'s Email: ___ Fax: __

Credentialing Contact Email: _____

*Please submit secondary locations on a separate sheet

1. **Malpractice Insurance Carrier**
   Name: Expiration Date: _____

2. **State License**
   Number: _____ Expiration Date: _____

3. **DEA Certificate** (Does not apply to D.C.)
   Number: _____ Expiration Date: _____

   (Submit copy of Malpractice, License, and DEA Certificate with this form)

I am submitting my $145 Annual Network Participation by:

Check #: MasterCard/Visa (American Express (

Card Number: _____

Exp. Date: _____ 3 or 4 digit security code: _____

I authorize the above card to be charged for my membership fee.

You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide or have provided to us. This may include text messages, automatic telephone dialing systems, prerecorded voice and/or fax. We do not sell or distribute our lists. This information is used for internal purposes only.

Signature: **Date:** _

PO BOX 71717, PHOENIX, ARIZONA 85050
VOICE 877-311-3338 FAX 602.485.3100
WWW.HNA-NET.COM

HEALTHCARE NETWORKS OF AMERICA
PHYSICIAN PROVIDERSHIP AGREEMENT

DATE: _____

PARTIES: **"Network": HEALTHCARE NETWORKS OF AMERICA**
A Limited Liability Company

"Provider": _____

RECITALS

1. Network has established a national marketing network through which it negotiates and obtains patient contracts and conduct general marketing activities.

2. Provider is a licensed provider who desires access to Network and additional benefits as are offered from time to time by Network, subject to and in accordance with the terms of this Physician Providership Agreement (the "Agreement").

AGREEMENTS

1. Providership.

   1.1 Credentialing fee. Provider shall pay to Network an initial annual network participation per provider.

   1.2 Term. The term of the Providership shall begin on the Effective Date, and shall automatically renew on an annual basis upon receipt of Provider's annual network participation then in effect, if any, as communicated by Network to Provider from time to time unless sooner terminated as provided herein.

2. Rights, Duties and Obligations of Provider. During the term hereof, Provider shall have the following rights, duties and obligations with respect to the Providership.

   2.1 Participation in Marketing/Contracting. Provider shall have the opportunity to participate in such marketing, and contracting programs as are developed or negotiated from time to time by Network. Such participation shall be on terms and conditions and subject to such costs and fee schedules agreed to from time to time by Network and Provider. Network intends to seek patient contracts on behalf of Providers with national and local employers and third-party payors. Provider shall be under no obligation to participate in any such marketing, advertising or patient programs

3. Rights, Duties, and Obligations of Network. During the term hereof, Network shall have the following rights, duties, and obligations with respect to the Provider. Obligation to notify payer contracts of new providers upon credentialing completion on a monthly basis.

4. Termination. This Agreement, and the Providership issued to Provider hereby, may be terminated as follows:

   4.1 Termination by Provider. Provider may terminate this Agreement, for any or no reason, on thirty (30) days' prior written notice to Network.

   4.2 Termination by Network. Network may terminate this Agreement, on thirty (30) days' prior written notice to Provider.

5. Indemnification

HNA and the provider(s) shall mutually indemnify and hold harmless each other from any and all claims and losses which each may suffer or incur as a result of any action by the other pursuant to the terms of this agreement, but only if such claims or losses are not due to willful malfeasance, bad faith, negligence or reckless disregard of its obligations and duties under the terms of this agreement.

6. Choice of Law. This Agreement shall be governed by and construed in accordance with the internal law of the State of Arizona, but not the conflicts or choice of law provisions thereof.

IN WITNESS WHEREOF, the parties have caused this Agreement to be duly executed and delivered as of the date first set forth herein.

You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide or have provided to us. This may include text messages, automatic telephone dialing systems, prerecorded voice and/or fax. We do not sell or distribute our lists. This information is used for internal purposes only.

"NETWORK"

HEALTHCARE NETWORKS OF AMERICA
A Limited Liability Company

Sign _____

Print _____

Address:

PO BOX 71717

Phoenix, Arizona 85050
Phone: 877-311-3338
Fax: 602-485-3100

"PROVIDER"

Sign _____

Print _____

Address:

_____

_____

_____

_____

Phone: _____

Fax: _____