



# Client Application

**C** Corporate Name \_\_\_\_\_  
**O** Address \_\_\_\_\_  
**M** Address \_\_\_\_\_  
**P** City/State/Zip \_\_\_\_\_  
**A** Phone \_\_\_\_\_  
**N** Legal Status:  Corporation  Partnership  
**Y** Business Type:  Hospital  Clinic  
 Group Practice  Indep Practice

**C** Administrator Name \_\_\_\_\_  
**O** Billing Officer Name \_\_\_\_\_  
**N** Fax \_\_\_\_\_  
**T** Fax \_\_\_\_\_  
**A** Specialty: \_\_\_\_\_ No. of Doctors: \_\_\_\_\_  
**C** Billing Method:  Bill - Due Upon Receipt  
**T**

Names/Addresses of Individuals or Partners	-or-	Name/Title/Phone Number of Corporate Officers
_____		_____
_____		_____
_____		_____

Name of Person to Contact Regarding Billing or Questions (Title, Address and Phone if Different than Above)
_____
_____

Bank Reference	Account Number, Contact, Title, and Phone Number
_____	_____
_____	_____

Trade References: Company Name, Address, Contact and Title, and Phone Number
_____
_____

<p>I understand that ipMedica is relying on this application in part to make a credit determination. I hereby certify the information to be true and agree to ipMedica payment terms and conditions.</p>	<p>SIGNED _____          TITLE _____          DATE _____</p>
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