

Provider ID Number	877.885.1258
Loan Amount Requested	Fax 775.546.6156
Down Payment	

First Name	Middle Initial	Last Name
Street Address	Apt/Unit	
City	State	Zip
Date of Birth		
Email Address*	Social Security Number	
Home Phone	Cell Phone	
Employer Name		
Work Phone	Annual Income**	How Long with Current Employer
		Yrs _____ Months _____

Repayment Method (Select One)			
Selecting a repayment method is required in order to process the application.			
<input type="checkbox"/> Credit Card	Card Type	Card Number	Expiration
<input type="checkbox"/> Bank Account Withdraw	Routing Number	Account Number	Account Type <input type="checkbox"/> Savings <input type="checkbox"/> Checking

Personal References (Not Living with You)	
First Name	Last Name
Phone Number	Relationship
First Name	Last Name
Phone Number	Relationship

Please Read the Terms and Disclosures Below

Authorization of Credit Information and Credit Policies Release

Upon submitting this application, I confirm that all submitted information found on this application is true and correct to the best of my knowledge, and allow MedChoice Credit Corporation and/or its assignee(s) to verify the submitted information, including, but not limited to, attaining my credit report, making contact with my employer for employment and income verification, and/or making contact with my Physician to verify the procedure type(s), procedure date, amount of deposit, amount of procedure(s) and remit payment on approval. I fully agree and understand that the Lender(s) (as defined in the Promissory Note or communication to me) can provide information regarding my account to consumer reporting agencies and others who may appropriately receive that information.

Furthermore, I am signing that a Physician staff member may submit on my behalf and that I have read this disclosure and agree to the conditions set forth. I also agree that this application and any information I submitted with it may be forwarded to other creditors. I understand that any offer of credit from such other creditors will be independent of MedChoice Credit Corporation, LLC. and may include different terms and conditions, including rates and fees, than those disclosed by MedChoice Credit Corporation, LLC.. MedChoice Credit Corporation or the other creditors, not MedChoice Credit Corporation, LLC., will provide me any required disclosures from such other creditors. I further agree that such other creditors may obtain a credit report and use it in making a credit decision.

*By providing your email address, you consent to receive commercial emails from MedChoice Credit Corporation for solicitation, advertising and promotions offers related to your MedChoice Credit Corporation Credit Card Account. You also consent for MedChoice Credit Corporation to share your email address with MedChoice for service and product offers.

**You do not have to tell us about alimony, child support, separate maintenance income or additional income unless you want us to consider them when we review your application.

Signature _____ Date _____

By signing applicant agrees to all terms and disclosures above.