MEMBERSHIP AGREEMENT

Physicians' Alliance of America

MEMBERSHIP IS FREE!

Practice Name (d/b/a) ______________________________ **Practice Specialty** ______________

Legal Name* ______________________________ **Tax ID # (EIN)** ______________

As shown on your income tax return

Are you Incorporated? ☐ **Yes** ☐ **No**

Total Number of Practice Locations _______

Year Practice Established __________

Total Number of Providers _______

Main Office Address:

____

____

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HIN# ______________________________

Phone ______________ **Fax** ______________

2nd Location if applicable (*attach an additional sheet if necessary*):

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HIN# ______________________________

Phone ______________ **Fax** ______________

List all physicians' names and DEA numbers (*attach an additional sheet if necessary*):

Physician Name(s)	DEA #

Office Manager ______________________ **Email*** ______________________

Purchasing Contact ______________________ **Email*** ______________________

Managing Physician ______________________ **Email*** ______________________

Username for Website ______________________

You must provide at least one valid email address.

How did you learn about Physicians' Alliance? ______________________________

All members will receive an electronic Purchasing Guide. Check here if you would also like a printed copy mailed to you. ☐

Terms and Conditions

It is my intention to join Physicians' Alliance of America to utilize preferred pricing and terms on products and services for a Medical Practice. As a member of PAA, I agree to keep all pricing and contract information confidential.

I agree that all products purchased through any PAA agreement shall be for Member's own use and will not be resold or redistributed to a third party.

I acknowledge that there is no membership fee to join or to access PAA contracts. For administrative and contract management services provided, I understand that vendor partners may pay PAA an administrative service fee of no more than 3% without appropriate notification to your medical practice.

PAA represents and warrants that its Group Purchasing Program and related activities comply with applicable state and Federal laws, including the relevant provisions of the Federal "Safe Harbor" regulations found at 42 CFR 1001. Your Medical Practice, by executing this Agreement, agrees to disclose and appropriately reflect any discount or reduction in price received in any cost report submitted to any governmental programs, including but not limited to, the Medicare and Medicaid programs.

This Group Purchasing Program Membership Agreement shall remain in effect for one year from the date of signature unless terminated by either party upon thirty (30) days advance written notice. Unless otherwise notified, this agreement shall renew for additional one-year periods on the anniversary date each year hereafter.

Signature______________________ **Print Name**______________________ **Title** ______________ **Date** __________

Fax to 770-446-9814 or e-mail to membership@physall.com. Questions? Call 866-348-9780 or visit physiciansalliance.com.