



an INGENIX company

ENS INTERNET PATIENT STATEMENT SET-UP SHEET

I. Account Information

Practice Name:		ENS User ID:
Contact Name		
Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	
Practice Management System:		
Vendor Name, Contact & Phone Number:		

II. Standard Information

Credit cards to be shown on Statement: Visa American Express MasterCard Standard Discover None

Approximate Monthly Volume: (requires 100 document minimum per month)

E-mail Address for File Receipt

Confirmation and File Processing Report:

1. _____

2. _____

Envelope: #10 Outbound with #9 Security Return Envelope

Please fax a sample of your current statement to 719-457-8366 with this set-up sheet.

III. Pricing

Remit address, if different than above:

Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	
Base Price/Statement (\$.65, \$.18 for each additional page):		
Special Statement Handling:		

As an additional consideration for the terms and conditions of sale by ENS to the undersigned, the undersigned agrees to indemnify and hold ENS harmless from and against any and all claims, litigation, and damages of every kind and nature, including reasonable attorney's fees, in any way arising out of the performance, including but not limited to negligence in performance, by ENS of the services set forth herein for the undersigned, whether said claims, litigation and damages are brought against ENS by the undersigned, those claiming by, through or under the undersigned, or by any third party.

It is imperative, ENS be notified in advance of any change in the physician's office software which could affect the format of the statement. Failure to do so will delay the billing process. This would include software updates.

Customer Signature: _____ Date: _____

ENS maintains a strict policy of collecting a postage deposit from all customers utilizing the statement processing and production service. This deposit is based on an estimate of your usage during a one (1) month period and will be credited to your account until termination of the service, whereupon it will be fully refunded, less any unpaid charges for services rendered. Please make deposit check payable to "ENS"

Monthly Patient Statement Volume _____ x \$0.65 rate = Deposit Amount \$ _____.

Please specify payment method for postage deposit required to start account.

e-Check: Routing # _____ Account # _____
Credit Card: Type: _____ Account # _____ Security Code: _____ Expiration Date: _____

Return this completed sheet with postage deposit to: ENS Sales Department
1755 Telstar Drive, Suite 400
Colorado Springs, CO 80920