CollaborateMD

TSYS

CollaborateMD
Integrated Payment Processing
Enrollment Data Form

Complete and send this page to Margaret Kowalski @ 303-482-8148 or mkowalski@tsys.com

☐ Individual Location ☐ Part of large group; Practice Name:_________________________

Please be sure to complete ALL of the following fields.

Practice Information – Details of the physical location where the credit cards will be accepted.

Legal Business Name: ____
DBA (if applicable): ____
IRS W-9 Info: Name as Used for Tax Reporting: ____
Address: ____
City: _______________________________________State: _____________ Zip: ____________
Phone: ____________________ Fax: __________________ email: _______________________
Primary Contact: ___________________________ Tax ID#_____________________________
# of Years in Business:_____
Type of Ownership: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC or LLP
If Sole Proprietor, Date of Birth: ____________

Principal Information – Details of the legal officer, owner, or partner of the practice

Name: ____ Title: _____________________
Home Address: ____
City: ______________________________ State: ________________ Zip: _________________
Home Phone: _________________________ SSN: ___________________________________
Ownership %: _________________________
Driver's License #: ______________ State of Issuance: _____ Issue Date: _____ Exp. Date: _____

Banking Information – Details of your deposit account

Bank Name: __________________________________ Years with this Bank: ________________
Account Number: ______________________________ Routing Number: __________________

Additional Information

Total Number of Card Readers Needed at $150 each: ____________

NOTE:
Your account will be automatically setup with Visa, MasterCard, Discover, and American Express.