TSCN
TRI-STATE SPECIALIZED CARE NETWORK
COORDINATED MUSCULOSKELETAL AND SPINE CARE

CONFIDENTIAL - BLANK AUTHORIZATION

TSCN Credit Card Charge Authorization

Doctor membership | Complete applicable amounts and select one tier. Sign once.

1 CHOOSE YOUR DOCTOR MEMBERSHIP TIER

- ○ TIER 1 - OBSERVER: $300 one-time onboarding and commitment fee; $0 monthly.
- ○ TIER 2 - CC ONLY: $350 per month per ten-hour unit; minimum one CC unit.
- ○ TIER 3 - CC + CM: minimum one CC unit and one specialty CM unit.

My specialty: _____ CM fee per unit: $ _____ / month

CC units (min. 1): _____ CC subtotal: $ _____ CM units (min. 1): _____ CM subtotal: $ _____

Tier 1: enter zero for all monthly units and charges. Tier 2: CM is zero. Tier 3: use the Flyer Marketing block column for the CM unit rate; its Total per month column already includes one $350 CC unit.

TOTAL CHARGE PER MONTH: $ _____ **DATE OF INITIATING:** _____

One-time charge: $300.00 Monthly total = CC units x $350 + CM units x CM unit rate.

2 DOCTOR AND BILLING DETAILS

Doctor member: _____ Practice: _____

Email: _____ Phone: _____

Cardholder name: _____

Billing address: _____

City: _____ State: _____ ZIP: _____

Card type: ○ Visa ○ Mastercard ○ Amex ○ Discover

Card number: _____ Expiry MM / YY: _____

3 CHARGE AUTHORIZATION AND SINGLE ACCEPTANCE

I authorize TSCN, LLC to charge the card identified above the separate $300 one-time onboarding and commitment fee and the total monthly amount completed above, beginning on the date of initiating. Paid CC and CM subscriptions have a minimum of three consecutive service months. Tier 1 has no monthly charge.

I understand that I can change or cancel this agreement after three months. After that minimum, I may request a prospective change or cancellation before the next scheduled charge. Fees and unit commitments may be reviewed every three months; any change requires prior written agreement. No unspecified amount or additional unit is authorized by a blank field.

My one signature affirms the Membership Pledge, accepts the Physician Membership Agreement and the fee schedule in the Doctor Flyer as updated in this packet, and authorizes the completed charges on this page. I confirm I am the physician member and authorized to use this card. Revoking card authorization does not erase fees already owed.

Physician member / authorized cardholder signature: _____ **Date:** _____

Return only through a TSCN-approved secure payment channel. Do not email completed card details.

Keep completed copies confidential. Do not record a CVV / CVC code on this recurring authorization.