



## Provider Agreement Direct-to-Provider Program

This Provider Agreement is entered into as of the date below by and between Prosper Healthcare Lending LLC, a Delaware limited liability company (“Prosper Healthcare”) with offices at 380 Data Drive, Suite 100, Draper, UT 84020, and the healthcare provider identified below (“Provider”) and Provider’s owner or officer identified below (“Principal”). In consideration of the mutual promises and covenants contained herein and in the Terms and Conditions found at <http://www.prosperhealthcare.com/directterms> (the “Terms”) which are incorporated in and made a part of this Provider Agreement (together with the Terms, this “Agreement”), the parties hereby agree as follows:

### Provider’s Business Information

\_\_\_\_\_  
Legal Business Name

\_\_\_\_\_  
DBA

\_\_\_\_\_  
\* Office Address (PO Boxes not permitted)

\_\_\_\_\_  
City, State\*, Zip Code

\_\_\_\_\_  
TIN (SSN if Sole Proprietor)

\_\_\_\_\_  
Business Phone Number

\_\_\_\_\_  
Primary Contact

\_\_\_\_\_  
Primary Contact Email

\_\_\_\_\_  
Website

\_\_\_\_\_  
# of Locations | Annual Revenue | # of Employees

### Principal (Owner/Officer) Information

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Home City, State\*\*, Zip Code

\* If Provider has multiple locations, please complete [Appendix A](#) attached to this Provider Agreement.

\*\* Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania.

### How is your business organized?

- Corporation       Sole Proprietor       LLC       Partnership       Not for Profit

## Medical Staff

Please list all doctors on staff:

**First Name**

**Last Name**

**Email Address**

**Affiliations/Memberships**

(ADA/ASPS/ASAPS etc.)

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## Medical Specialty

Dental

Cosmetic/Plastic Surgery

Other \_\_\_\_\_

Do you perform dental implant procedures?  Yes  No

If "Yes", what percentage of the total procedure amount do you collect upfront? \_\_\_\_\_%

## Procedures and Treatments

What are your 3 most common treatments or procedures that you finance and their standard price?

**Treatment/Procedure**

**Price**

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## Usage

How many of your patients currently apply for third party financing on a monthly basis?

\_\_ 0-2 patients a month

\_\_ 3-4 patients a month

\_\_ 5-10 patients a month

\_\_ 11-20 patients a month

\_\_ 21-40 patients a month

\_\_ 40+ patients a month (please specify how many \_\_\_\_\_ )

How do you plan to refer patients to Prosper Healthcare?

\_\_ I will refer my patients to Prosper Healthcare first, before any other financing option (recommended).

\_\_ I will refer my patients to Prosper Healthcare at the same time as I refer them to other financing options.

\_\_ I will refer my patients to Prosper Healthcare if they are declined by other financing options.

## Training and Website Setup

Before Provider may refer potential Borrowers to the Program, Provider must place Program link on Provider's website and complete Prosper Healthcare's required training. The website link must be active on Provider's website before training and activation call.

Preferred Time of Day for Training Call: (10:30am – 5:30pm Eastern Time) \_\_\_\_\_

Contact for Website Link setup (Name, Phone, Email Address) \_\_\_\_\_

Individuals to Receive Training:

*Any staff member who will discuss Prosper Healthcare with patients, use Prosper Healthcare's product, or interact with Prosper Healthcare must receive training.*

First Name	Last Name	Title	Phone	Email Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## Direct Deposit Information

(Must attach a voided check for funding account)

Bank Name \_\_\_\_\_

Name on Account \_\_\_\_\_

Routing Number \_\_\_\_\_

Account Number \_\_\_\_\_

Account Type     Checking     Savings

Please attach voided check here



## Do you want to refer patients for Promotional 0% Financing?

Some healthcare providers prefer to refer patients for 0% interest products only for certain dollar amounts.

Please select the loan amounts for which you would like to refer patients for 0% products; Provider will pay the Practice Fee associated with any Promotional 0% Financing.

Please select one of the options below.

✓	Loan Offerings	Standard Loans Practice Fee: 0%	12 Mo. 0% Interest Practice Fee: 8.99%	6 Mo. 0% Interest Practice Fee: 4.99%
<input type="checkbox"/>	<b>Option A</b> (I do not want to refer my patients to promotional interest products)	\$2,000 - \$35,000	N/A	N/A
<input type="checkbox"/>	<b>Option B</b> (I want to refer my patients to 6 and 12 month 0% interest, but only for certain loan amounts)	\$2,000 - \$35,000	\$2,000 - \$7,500	\$2,000 - \$7,500
<input type="checkbox"/>	<b>Option C</b> (I want to refer my patients to 6 and 12 month 0% interest for all loan amounts)	\$2,000 - \$35,000	\$2,000 - \$35,000	\$2,000 - \$35,000

By signing below, Provider hereby authorizes Prosper Healthcare, its parent or any of its affiliates or banking partners to initiate electronic credit or debit entries to my designated banking account ("Settlement Account") at the financial institution indicated above for the disbursement and collection of any amounts in connection with this Agreement. Provider acknowledges that the origination of electronic credits or debits to the Settlement Account must be permitted by Provider's financial institution, which must be located in the United States. Provider represents and warrants that the Settlement Account is used primarily for commercial purposes. Provider understands that this authorization will remain in full force and effect until Prosper Healthcare has received written notification from Provider of its termination in such time as to afford Prosper Healthcare and Provider's financial institution a reasonable opportunity to act.

By signing below, Provider and Principal further authorize Prosper Healthcare or its agents (including Prosper Marketplace, Inc.) to make one or more "soft" credit inquiry(ies) (which will not affect a credit score) from one or more consumer credit reporting agencies or other data providers for any purpose relating to this Agreement that would be permitted by applicable law during the term of this Agreement. This authorization may be withdrawn at any time by the method described in the Terms.

By signing below, the Principal represents that the undersigned has read the Terms and that the undersigned is authorized to bind Provider to the terms of this Agreement. In the event of any default of Provider under this Agreement, Principal hereby personally guarantees payment of any amounts due to Prosper Healthcare. In witness whereof, the parties have executed this Agreement as of the date below.

**PROVIDER**

By \_\_\_\_\_

Name:

Title:

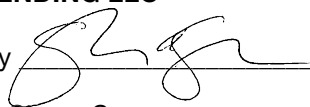
Dated \_\_\_\_\_,  
2016

**PRINCIPAL**

By \_\_\_\_\_

Name:

**PROSPER HEALTHCARE  
LENDING LLC**

By  \_\_\_\_\_

Shaun Sorensen

Vice President



## Appendix A Additional Provider Locations

### Location 2

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

### Location 3

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

### Location 4

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

## Location 5

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

## Location 6

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

## Location 7

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

## Location 8

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

\*Program not available in Iowa, Maine, Vermont, North Dakota and Pennsylvania

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.

## Location 9

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Location Name

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Main Contact

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Address

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Phone

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City, State\*, Zip Code

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Main Doctor on Staff

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- Please check here to confirm that this location is wholly-owned by Provider.
  - Please check here if this location uses a separate bank account from Provider.