



Phone (702) 944-4188  
Fax (702) 921-6087  
6391 Tempting Choice Ave  
Las Vegas, NV 89131

www.presettlementhealthcare.com

email admin@presettlementhealthcare.com

## APPLICATION

Business Name: \_\_\_\_\_ Date Established: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Firm Organization Type: \_\_\_\_\_

\_\_\_\_\_  
Sole Proprietorship, Partnership, LLP, LLC, PC, PLLC, APLC, PA, Other (*please specify*)

Tax Identification #: \_\_\_\_\_

Is the business name the same name that attorneys are invoiced under? Y/N

If no, please list name business name here: \_\_\_\_\_

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### Accounts Receivables Contact

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_ email: \_\_\_\_\_ Hours \_\_\_\_\_

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### Additional Information

Are there any other d.b.a., or Fictitious Business Names used: Y/N

If yes, please list here: \_\_\_\_\_

Officer and title of person authorized to assign or sell receivable assets:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Are receivables currently or previously collateralized? Y/N If yes please explain.

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**Estimates of Attorney Accounts Receivable**

Approximate number of accounts: \_\_\_\_\_

Average monthly attorney billings in dollars: \$ \_\_\_\_\_

Average invoice amount: \$ \_\_\_\_\_ Average annual write down: \$ \_\_\_\_\_

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**Supplement**

I do hereby authorize Pre-Settlement Healthcare Funding, LLC (PSH) to complete a corporate credit check to verify any liens or judgments. Furthermore, I understand that the application process is not an offer to finance. A purchase agreement with terms will be presented by PSH or a vendor of PSH with terms and agreement for purchase of attorney liens.

The undersigned is authorized to submit application for a purchase agreement requiring the assignment or sale of attorney lien or letter of protection invoices or account receivable related to personal injury clients represented by attorneys.

PSH will require a copy of the imaging results of each client. In providing our firm a copy of the results and or other medical records, please make sure you are in compliance with HIPAA. If you need a HIPAA release form please let us know.

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Date*