

CONSULTATION AGREEMENT



Appointments can be made and set from our website and the following links:

- Joseph Graves: <https://calendly.com/joewagency>
- Abigail Watrud: <https://calendly.com/Abigail-19>
- Or directly on our website www.pbba.com

Fax to (631) 369-0618 Email to PBBA@washwick.com

I, _____, wish to have a full consultation with The Washwick
PRINT NAME

Agency, and have read and acknowledge agreement with the following:

- The **\$150** consultation fee is due at time of appointment, and is payable by cash, check, money order, or credit card form. Refund requests made after completed consult will be denied. Consults are non refundable.
- **The Consultation includes:**
 - Needs assessment of my current insurance budget, needs and wants
 - Discussion of plans that are available to you including breakdown of out of pocket costs, copayments, and specific benefits.
 - General tutorial about health insurance including details about deductibles, coinsurances, family maximums, and more.
 - Hospital listing and review of difference in hospital networks
 - Corresponding Marketing pieces, website information and formularies from insurance companies.
 - Availability after consultation to answer questions or confirm information via email or our website at www.pbba.com. (if on telephone or in office further charges will apply)
 - Recommendation for coverages to meet current need based upon consultation discussion.
 - **I understand that the based upon need, I may be shown and offered products that are commissionable to the agent. The Commissions for individual products are listed on the pbba website as well as in the packet provided. Service charge is for consultation and is not waived in the event a purchase is made where commission will be paid to agent.**
- **The Consultation does NOT include:**
 - Assistance with completing full Application for coverage and submission to insurance company of choice.
 - The Washwick Team does not make decisions on your behalf; we are here to enable you to make an informed decision.
 - We cannot provide you with look ups and confirmation of current doctors in the network. After the one-hour consultation appointment, additional charges may be applied for support and services via phone.
 - Look up and review of prescriptions.

I confirm that I understand what services The Washwick Agency/PBBA does and does not offer, and what The Washwick Agency does or does not take care of. I understand that The Washwick Agency is not responsible for loss of coverage for nonpayment or denial for late or incomplete applications. The Washwick Agency and PBBA are not responsible for coverages not purchased or reviewed based upon Consultation. The suit of products shown are based upon availability and needs at time of Signed Consult.

SIGNATURE

_____/_____/_____
DATE

EMAIL ADDRESS

PBBA #

The Washwick Agency, Inc.
Peconic Bay Business Associates
860 East Main Street, Riverhead, NY 11901
PBBA@washwick.com (631) 369-0888

PAYMENT FORM



I _____ Authorize the Peconic Bay Business Assoc. / Washwick

Agency to take payment for the \$150 2019 Consultation in the following format:

If I do not pay the amount due within 30 days I understand there will be a \$10 late fee for each month unpaid.

Consultations are non refundable.

CREDIT CARD

Credit Card: (please circle one) **VISA** **MASTERCARD**

If card is declined, I understand I will be invoiced \$15 Declined charge along with outstanding balance.

Account Number _____

Expiration Date: ____/____ **3 Digit Security NO:** ____ (located on back of card)

Card Holder Name: _____ Exactly as printed on card.

Billing Address: _____

CITY _____ **ZIP** _____

PHONE: () _____ - _____

SIGNATURE: _____ **DATE:** _____

CHECK

CHECK OR MONEY ORDER PAYMENT:

I prefer to make a payment via check or money order. I understand if my check bounces I will be invoiced for the total amount plus a returned check fee of \$50.00.

Payment via Check # _____ **Amount \$** _____

Name on Account _____ **Money Order#** _____

SIGNATURE: _____ **Date:** _____

INVOICE

I PREFER to be invoiced the Processing and or Consultation fee and promise to pay within 30 days. I understand if my balance remains unpaid within 30 days the PBBA has the right to take action including a \$10 late fee for each month I have not paid leading up to Collections.

Please send my INVOICE to the following:

EMAIL _____ **Full Name** _____

ADDRESS: _____ **Phone:** _____

SIGNATURE: _____ **Date:** _____