

Practice-Web Inc.
P. O. Box 4678
El Dorado Hills, CA 95762
(800) 845-9379 Sales/Fax



Cloud-Form Registration & Subscription Agreement

I, _____, the undersigned, with office
located at _____

agree to pay \$99/year starting _____, 2017 for cloud-based patient registration for the duration of 12-months including telephone support for Cloud Forms Service. I authorize Practice-Web Inc. to charge \$99 to my credit card below which will be automatically renewed at \$99 after one year unless cancelled within 30 days of after the end of 12 months. A cancellation fee of \$50 applies for any cancellation after 30 days of use.

If my credit card transaction is declined or and payment is past due, a \$20 late fee will apply to current balance.

I Dr. _____ understand that cloud-based registration is a separate service (unlimited use) provided by Practice-Web Inc. It includes standard forms for patient registration, health history questions, HIPAA Privacy and financial arrangements forms which can be linked to my website. Customization charge for each form is \$50 or \$100 for a new form with background image. Customer can modify existing forms with instructions.

Dr. _____ Date _____

Name as printed on Credit Card _____
Card type Visa MasterCard Amex Discover

Card Number _____

Expiration Date _____ 3 or 4 digit security code _____ (back of card)

Billing address _____

City, State, Zip _____

Please fax back to 1-800-845-9379 or 916-987-7551.