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

E.H.R Purchase Agreement and Memorandum of Understanding for Medicaid E.H.R Incentive Program

Eligible Professional (E.P.):_____

E.P. NPI Number:_____

Please Check if you are : ☐ Adopting ☐ Implementing ☐ Upgrading

Vender ONC # _____

Software version and Date certified:_____

E.P. Practice Address:_____

Practice City, State, Zip _____

Name of authorized contact:_____Phone:_____

Email:_____

Practice Title:_____

(exactly as it will be entered in the Practice-Web interface under Setup Menu, Practice).

Providers:

Please enter the exact first and last name of each provider who will use the EHR functionality. Enter the names exactly as they are entered in the Practice-Web interface under Lists menu -> Providers.

	First Name	Last Name		First Name	Last Name
1			6		
2			7		
3			8		
4			9		
5			10		

Please note that in order to receive certified EHR version of Practice-Web and annual EHR keys, a calendar year commitment is required. Practice-Web does not guarantee payment from government agency by employing the EHR version of the software.

I_____, the undersigned agree to pay EHR version annual license fee of _____ per calendar year (or part thereof) per provider for aforementioned provider(s). I will renew support for another calendar year if necessary. I understand that I will receive E.H.R. keys per calendar year to run meaningful use reports starting with 2014 EHR edition. Once the EHR keys have been applied for, the registration fee cannot be refunded. Any cancellation within three business days after signing this form will incur 3% card processing fee. If I cancel the EHR usage prior to the end of calendar year period then entire remaining balance for EHR keys will be due.

_____ 03/04/15

Provider Signature (E.P.) Date (contd.)

By signing this agreement Practice-Web hereby certifies that (name of E..P)_____ has paid for and has _____Adopted _____Implemented _____been upgraded to Practice-Web Version _____

ONC certification#_____

The eligible professional understands that they are soley responsible for data entry and reporting as required to report for meaningful use and attestation. The signee understands that MediCare EHR incentive payments made to this provider will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

_____ 03/04/15

Provider Signature (E.P.) Date

_____ 03/04/15

Signature of Vendor Representative Date