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

practice-web
Mobile enabled Cloud-based Solutions

Serving Dental Community since 1988

PWDentistPortal™ Subscriber Agreement

I, _____,the undersigned, with office located at

_____

agree to pay $99/year per provider per database starting _____,2017 for cloud-based patient and appointment information access for the duration of 12-months including telephone support. I understand that additional provider access is $20 per provider per year. I also understand that in order to add or remove a provider from the Dentist Portal subscription a written notice will be required. I authorize Practice-Web Inc. to charge $99 to my credit card below (30-day free trial) which will be automatically renewed at $99 after one year unless cancelled within 30 days prior the end of 12 months. A cancellation fee of $50 applies for any cancellation after 60 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.

Security:
The Customer is responsible to ensure that others do not gain unauthorized access to their server computer by taking appropriate security measures. The Customer is solely responsible for any and all transmitted contents. The Vendor makes no representation or warranties with respect to or in connection with security or confidentiality of data transmission. In no event shall Vendor be liable for any loss of content or other claims, losses, actions, damages, suits resulting from unauthorized access. The Vendor may collect and accumulate demographics & non-personalized information about the Customer's patients. The Customer agrees that it has given its informed consent for the collection and use of Customer's information as described herein. The Vendor represents and warrants that it shall comply with HIPAA Privacy requirements for protected information.

_____ 04/06/17
Dr. Date

Payment Information:
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 800-845-9379 or 916-987-7551

Submit