

ProviderPROsm Subscription Form

Use this form to subscribe to ProviderLAW's Subscription Service Described on ProviderLAW's web site

Part 1: General Information

CLINIC INFORMATION

Name of Healthcare Clinic: _____

Primary Contact Name: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Business E-Mail Address (One Only): _____

Do You Have a High-Speed Internet Connection (Cable, DSL), or is Your Connection a Dial-Up? High Speed Dial-Up.

How Did You Learn About ProviderLAW, i.e., Who Referred You? _____

Names of Insurance / Billing Staff: _____

Specialties Employed by Your Company (Check All That Apply): DC PT DC MD Other: _____

PAYMENT OPTIONS & PRICES – PLEASE COMPLETE

Term: 1-Year Variable Other: _____

The amount of the Initial Sign-Up Fee: \$199

Total Amount of One-Time Payment (if you wish to pay upfront for the subscription period): \$1747

Amount of Monthly Installment (if you wish to pay on a monthly basis; Initial Sign-Up Fee is not included): \$129

ACCEPTANCE OF SUBSCRIPTION TERMS

I, the below-signed individual, on behalf of my company, state that I have read, understood, and agree to the Terms of the Legal Notice ("Terms") located on the ProviderLAW website at http://www.providerlaw.com/legal_notice.php. I further agree that the Terms also include either Part 2 of this application form (payment by monthly bank draft) or Part 3 (one-time payment by credit card) as elected by me, or other terms as set forth in a subsequent Part. I understand that all Terms including prices are subject to change at any time. I further agree that the Resources of ProviderLAW and/or of other Ancillary Entities do not constitute legal advice, cannot be relied upon as legal advice, and do not establish a client-attorney relationship. Such Resources are provided for educational, awareness, and discussion purposes only and as such, are provided strictly as samples or illustrations. While ProviderLAW and other ancillary entities may be able to assist my company in finding an attorney, unless otherwise stated, ProviderLAW and other Ancillary Entities are not law firms and do not offer legal representation to any third-party. I understand that if I have questions of a legal nature, I should contact an attorney at law.

Signature (Required) _____ Today's Date: ____/____/____

Your Name: _____ Title: _____

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Complete Part 2 if your clinic wishes to pay the subscription fee by monthly bank draft.

Part 2: Terms of Monthly Bank Draft

I, the below-referenced individual, am an authorized signor of the bank account listed below, and hereby agree to the following:

1. The purpose of this Part is to guarantee and provide a method of payment for the Clinic's subscription to ProviderLAW.
2. I authorize ProviderLAW to immediately debit the bank account in the amount of the Initial Sign-Up Fee (unless the Sign-Up Fee has been waived, or is otherwise expressly inapplicable). I further authorize ProviderLAW to begin debiting the bank account thereafter once per month within 3 days of either the 1st or the 15th day of the month, at ProviderLAW's election and at the rate indicated in Part 1 or in my current agreement. I understand that the subscription fees are subject to increase pursuant to the terms of this Agreement following completion of the initial subscription period.
3. I agree to maintain at all times a sufficient balance in the bank account to facilitate debiting pursuant to this Part. If for any reason ProviderLAW is unable to draft the bank account, I will work with ProviderLAW to facilitate the debiting process and if necessary, will immediately provide alternative account information for debiting purposes.
4. Except where provided otherwise to the contrary, this authorization will remain in effect until the earlier of the following events: (1) any authorized signor listed on the account notifies the relevant financial institution in writing that the draft is no longer desired, allowing the institution reasonable time to act upon such notice, or (2) the Clinic submits a request to cancel the draft to ProviderLAW in writing through certified mail at least fourteen (14) days prior to the next draft. In the event that the Clinic fails to notify the financial institution or ProviderLAW of its desire to stop or cancel the draft as stated herein, the financial institution and ProviderLAW shall be held harmless respectively for any failure to stop the draft. Should the monthly draft be discontinued or cancelled, the entire amount of any unpaid balance of the subscription fee shall become immediately due and payable to ProviderLAW.
5. I understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to the account. If an erroneous debit entry is charged against the account, any authorized signor shall have the right to have the amount of the entry credited by the financial institution, provided that the signor gives the financial institution written notice in a timely fashion identifying the entry, stating that it was in error, and requesting credit back to the account. For the purposes of this Part, "timely" shall be the earlier of the following: (1) 15 calendar days following the date on which a statement of account is received, or (2) 45 calendar days from the date written notice of such entry is received.

Bank Account Information

Name of Healthcare Clinic Applying for Subscription: _____

Type of Bank Account: Checking Savings

Bank Account #: _____, Bank Transit #: _____

IMPORTANT! PLEASE ATTACH A COPY OF A VOIDED CHECK TO YOUR APPLICATION FORM.

Name of Financial Institution: _____

Actual Name on Bank Account: _____

Name of Authorized Signor: _____

Authorized Signature: _____ Date: _____

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Complete Part 3 only if your clinic wishes to pay the subscription fee by a one-time charge to a credit card.

Part 3: Authorization for One-Time Charge to Credit Card

I, the below-referenced individual, am an authorized signor of the credit card account listed below, and authorize ProviderLAW to charge the account on a one-time basis in the amount selected or indicated in Part 1, plus the Initial Sign-Up Fee (unless the Sign-Up Fee has been waived, or is otherwise expressly inapplicable).

Credit Card Information

Name of Healthcare Clinic Applying for Subscription: _____

Credit Card Type: Visa MasterCard American Express Discover

Credit Card Number: _____

Expiration Date: ___/___ Name on Card: _____

Authorized Signature: _____ Date: _____