Subscriber Agreement for PWPatient Survey™ Service

This agreement is made on _____ day of_____ by and between Practice-Web Inc. ("Vendor") located in El Dorado Hills, California and Dr._____ _____("Customer") whose office is _____ _____
Practice-Web Inc. agrees to provide you ("Customer") with the use of PWPatient Survey Service ("Service") on a month-to-month basis starting on _____, 2014.

1. Service
The Service includes initial setup of Patient Survey task, starter training (up to one hour web-based) upload of marketing materials (once every month or 12 times per year) for the Customer's office (as per Appendix I). Based on customer's preference all patients with completed or broken appointments from Practice-Web appointment scheduler will receive an email at the end of the day. The Vendor will also provide support and updates for the front-end application (PWPatientSurvey) during the paid usage period. Vendor will help setup links to customer's Google+, Yahoo Places and Yelp accounts if available for a separate fee. Customer shall be responsible to maintain Google+, Yahoo Places and Yelp accounts in good standing after initial setup.

2. Payment Terms
After the conclusion of the 30-day free trial, Customer agrees to pay $49 per month (regular $69/month) per location for unlimited email messages per month. One time setup fee is $100. Customer is responsible to set up accounts for Google+, Yahoo Places and Yelp if desired. If the customer has signed for PromptCalls Reminder Service then the combined discounted charge would be $149/month (regular $198/month).

I, the undersigned authorize the Vendor to debit my bank account (separate ACH agreement is required) for monthly charge of $49 per month (price subject to change with 30-day written notice) for the aforementioned service. I can cancel the Service with 30-day written notice to Practice-Web Inc. If my ACH debit transaction is declined or and payment is past due, a $20 fee will apply to that month’s payment. If two consecutive transactions are declined, a late fee of $40 shall apply.

3. 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.

4. Maintenance
The customer shall maintain scheduled patients' valid email addresses for the service to function. The Vendor may perform scheduled and unscheduled maintenance to the Service. The Service may not be available during such times. The Customer acknowledges and agrees that the Vendor shall not be liable for any losses, claims arising out of any interruption of the Service as a result of maintenance activity.

5. General Provisions

Waiver. No Waiver by Vendor or the Customer of any breach or default by the other of any of the other's obligations under this Agreement shall be deemed to be a waiver of any other breach or default of the same or any other nature. Vendor is not responsible for loss of communication to patients due to unavailability of the local server, lost Internet connection, invalid or blocked emails. No failure by Vendor or the Customer on any one or more occasions to exercise any right or remedy provided in this Agreement shall preclude the exercise of such right or remedy on any other occasion.

Binding Effect. This Agreement shall be binding on and for the benefit of Vendor and the Customer and their respective legal representatives and successors.

Entire Agreement. Any oral or written statements, understandings, correspondence, purchase orders, or agreements previously made by Vendor and the Customer with respect to the subject matter of this Agreement are merged into this Agreement, which alone fully and completely expresses the respective obligations of Vendor and Customer.

Governing Law. This Agreement and all rights, remedies, and obligations under this Agreement, including matters of construction, validity, and performance, shall be governed exclusively by the laws of the State of California.

Effective Delivery. A party's transmission by facsimile or by electronic signature of a copy of this Agreement duly executed by that party shall constitute effective delivery of the Agreement.

_____ _____

Dr. Date

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

practice-web™
Paperless Office Solutions

Serving Dental Community since 1988

Appendix I
Setup Questionnaire

Office Name:_____

Dentist Name: _____

Main Office Number: _____

Email address used to send messages: _____

Email address used to receive messages: _____

How do want to sign-off the email to patients? e.g. Practice Name ___ Yes ___No
Dentist Name ___ Yes ___No
Office Phone ___ Yes ___No

File name (jpg, gif, tiff or png format) to upload for marketing purpose (once a month):_____

Send survey email to patient on:	**Starting At:** *6 PM*	**Day of Appointment** *e.g. Monday*
Monday		**Monday**
Tuesday		**Tuesday**
Wednesday		**Wednesday**
Thursday		**Thursday**
Friday		**Friday**
Saturday		**Saturday**

Following authorization is required to submit survey answers by patients for customer's review.

Patient Authorization

I authorize my provider and Practice-Web, Inc. to publish my review on the Practice-Web website, together with my first name. The purpose of publishing my review is to make it available to patients and prospective patients of my provider, and other members of the public. I understand that my provider and Practice-Web will not publish any personal information about me, except my first name, first initial of last name and what I have written in my review. I understand that my review and my first name and first initial of last name will be publicly available on the Internet, will not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization expires five years from the date you check "I Agree to the terms of the Patient Authorization" and click on "Submit my Feedback".

I understand that I may refuse to sign this authorization by closing this window without checking "I Agree to the terms of the Patient Authorization", and that my provider may not condition treatment, enrollment or eligibility for benefits on my signing this authorization.
I understand that I may revoke this authorization at any time by emailing support@practice-web.com with my name and a request to revoke my Patient Authorization. My revocation will be effective only when Practice-Web actually receives it. My revocation will not be effective to the extent that Practice-Web or my provider has acted in reliance on this authorization.

By checking the "I Agree to the terms of the Patient Authorization" and clicking on "Submit my feedback" you will be signing this Authorization for legal purposes.

DOCPAY™

Repetitive ACH Authorization

☐ New Payment Plan ☐ Change an Existing Plan

CLIENT NAME	ACCOUNT ID (IF APPLICABLE)

RESPONSIBLE PARTY (Name on the checking account)

NAME (FIRST-MIDDLE-LAST)	FEDERAL TAX ID - -
OFFICE PHONE # ( )	EMAIL ADDRESS

FINANCING INFORMATION: Monthly payment will be paid directly from your bank account.

BALANCE DUE	PAYMENT	TRANSACTION FEE (by Practice-Web)	TOTAL PAYMENT	PLEASE CHECK BOX FOR YOUR PAYMENT DATE(S)	START DATE
				☐ 3RD ☐ 10TH ☐ 18TH ☐ 25TH	

"I hereby agree to the 'Terms & Conditions' shown below and authorize the automatic debiting of my bank account according to the above payment schedule until the 'Balance Due' shown above is paid in full. **I agree to provide notice of any change to my bank information at least 1 week in advance of the next payment date.**"

SIGNATURE OF RESPONSIBLE PARTY	DATE

EITHER ATTACH VOIDED CHECK *OR* LIST BANK INFORMATION BELOW. (Do NOT use a deposit slip!)

Bank Name_____ Phone _____

Bank Address_____ _____

City_____ State _____ Zip _____

☐ Checking Account ☐ Savings Account Check # (from sample check)_____

BANK ROUTING NUMBER:	ACCOUNT NUMBER:

TIPS TO IDENTIFY ROUTING AND ACCOUNT NUMBERS:
There are three sets of numbers along the bottom line of your check the Bank Routing Number, the Account Number, and the check number The easiest way to identity each of these is through the process of elimination. First, eliminate the check number. This will leave the Routing number and account number The [: symbols will always be at the beginning and end of the 9 digit Routing Number. The account number is what is left over and will be anywhere from 5 to 16 digits

⑆123456789⑆ 1234 123456789?

Bank Routing Number Always 9 Digits | Check Number | Account Number 5-16 Digits

FAX COMPLETED FORM TO 800-845-9379

TERMS AND CONDITIONS

DOCPAY is a trade name of Complete Systems, Inc. and has been authorized by Practice-Web Inc. to administer this payment plan. The transaction fee indicated above is applied each time the Responsible Party's account is debited. Should there be insufficient funds in the account, additional debits may need to be processed. **There is a return charge of $10.00 for all returned items.** Upon default of the above payment schedule due to Insufficient funds withdrawal of the authorization, nonpayment or bankruptcy, the entire unpaid balance may, at the option of Practice-Web Inc. be declared immediately due and owing. In such cases Responsible Party agrees to pay the reasonable cost of collection and/or attorneys fees as permitted by the governing laws of the state. Neither Practice-Web, Depository nor Complete Systems, Inc. is liable for any incidental or consequential damages stemming from the transfer of funds unless due to fraud or willful misconduct. Responsible Party should receive a monthly statement from the above listed bank showing funds transferred. DOCPAY does not collect insurance payments.

REQUIRED INFORMATION - PAY PLAN CANNOT BE PROCESSED WITHOUT THIS!

CUSTOMER NAME	I.D. CODE	PHONE #
PRACTICE-WEB INC.	29691	800-845-9379

Your monthly payment will appear on your bank statement showing **DOCPAY ACH** as the payee.

In the event a payment is rejected or returned unpaid, a $10.00 NSF fee will be added to your account.

If you change your bank account, you must notify Practice-Web at least 15 days prior to your next payment date.

For account changes or any other questions regarding your account please call your Practice-web contact.