

Doctors Help Online

WEB SITE CUSTOMIZATION



YES

my firm wants to benefit from the *Doctors Help Online* Hosting Service. I understand that my site will be updated and maintained by the Medical Practice Management experts at MHM and that my site will be hosted by MHM. I also understand that the “contact us” button on the site will be pointed to an e-mail at my office.

Web Site Customization

The site will be customized with your name and logo. The “contact us” button on your Web site will be directed to an e-mail address at your office. Your Web site will have a unique URL with its own suffix. For example, Smith, Anders, & Smith CPAs would be www.drshelponline.com/sascpa.

Fee

The fee for this service is \$50 per month. The fee is waived for the first six months, after which you can continue the service for \$50 per month or cancel your subscription. Please complete the Payment Authorization Form to select payment option.

Customization Information

Please contact me about a custom-designed splash page.

Logo: Logo on file at MHM Digital logo file to be provided.
(Acceptable file formats include: psd, ai, gif, jpg, tif, and eps.)

Web site URL preferred: www.drshelponline.com/ _____

E-mail address for “contact us” button on your Web site: _____

Your Firm Information

Name _____ E-mail _____

Firm _____ Web Site _____

Street Address _____ Suite _____

City _____ State _____ Zip _____

Phone _____ Fax _____

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MHM Publications

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Doctors Help Online

PAYMENT AUTHORIZATION



Beginning 6 months from ____/____/____ (mm/dd/yy), I agree to pay \$50 per month for **Doctors Help Online**. If I choose to cancel, I will notify MHM in writing.

Monthly Fee Authorization (Select only one)

Credit Card Information

Credit Card: MasterCard VISA AMEX

Card Number: _____ Expiration Date: _____

Exact Name on Card: _____

Authorized Signature: _____ Date: _____

Electronic Funds Transfer Information

Company Name: _____

EFT Contact Name: _____

Beginning six months from the above date, I hereby authorize MHM Publications, to initiate variable debit entries to my: Savings Account or Checking Account, indicated below and my financial institution named below to debit the same to such account.

Bank Account Number: _____

Bank Routing Number: _____

Financial Institution: _____

Branch/City/State: _____

This authority will remain in full force and effect until MHM Publications has received written notification from me of its termination in such time and manner as to afford MHM Publications a reasonable opportunity to act on it.

Authorized Signature: _____ Date: _____

****A voided check must be provided****

Staple/Copy voided check here

Fax or Mail to: **MHM Publications**

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