



Contact Information

Practice Name: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Phone: _____ Email: _____

List Clinic Locations: _____

How many physicians would like to subscribe? _____
(\$75.00 per physician per month, \$225.00 per quarter, \$900.00 per year)

How many fellows would like to subscribe? _____
(\$50.00 per fellow per month, \$150.00 per quarter, \$600.00 per year)

List Physicians: _____

Would you like to be billed monthly, quarterly, or annually?

Which PRISM™ Package Would You Like?

Practice Management Software / EHR: _____

Additional PRISM™ Services

Check from the list below and we will provide a quote based on your unique needs

Integration Kit for your Practice Management Software and/or EHR

Integration benefits consist of, but are not limited to no data-entry redundancy, availability of utilization data for payment negotiations and to expand on best practice, more benchmarking data, automated scheduling of the PHAs. Costs of integration are estimated to be between \$2000 - \$3000; based on a rate of \$150/hour to remotely program the integration kit with EHR and/or practice management software. (You will be billed separately for this service)

Onsite Training and Implementation support

Onsite clinical and/or IT support for implementation including physician and staff training: \$1,200 per day plus agreed upon travel budget. (You will be billed separately for this service)

By Subscribing to PRISM™ I agree to accept the terms of the License Agreement Which can be viewed at: http://procareresearch.com/subscribe_license.html.

Payment Information

Amount enclosed: \$ _____

What is your payment method? Check Credit Card

When paying by check please mail this completed form along with your payment to:

ProCare™ Research, LLC
Attn: Rebecca Risko
61 Commerce Ave SW
Grand Rapids MI 49503

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Credit Card Payments

Please complete the following and fax your payment to Rebecca Risko at: 616-242-2503

Credit Card Type: Visa MasterCard Amex Discover

Name on Card: _____

Billing Address: _____

Credit Card Number: _____

Exp Date: _____ / _____ 3 digit code on back of card: _____

Authorized Signature _____