

Website Enrollment

PRACTICE NAME: _____

PERSON COMPLETING FORM: _____ TITLE: _____

1. Contact Person for Website Business

Contact name: Dr. Ms. Mrs. Mr. _____

Title: _____ Phone: _____ Ext.: _____

E-mail*: _____ Fax*: _____

*E-mail and fax are required. Our communication is conducted via e-mail, and secondarily by fax. We do not give your contact information to other businesses without your permission.

2. Website Preferences

Preferred website address: www. _____ .com

TIP: We recommend matching your practice name and keeping it simple, e.g., abcpractice.com. (Decision not required at this time. We can help you select one later.)

Preferred template color: _____

3. Practice Information

Main address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Current website address: _____

Business hours at main location:

	Mon	Tue	Wed	Thu	Fri	Sat
AM						
PM						

4. Physicians (Attach separate page if needed.)

	Title(s) (e.g., MD)	Board Certified?
1. Name: _____ E-mail: _____	_____	<input type="checkbox"/>
2. Name: _____ E-mail: _____	_____	<input type="checkbox"/>
3. Name: _____ E-mail: _____	_____	<input type="checkbox"/>
4. Name: _____ E-mail: _____	_____	<input type="checkbox"/>

PRACTICE NAME: _____

5. Patient Education

Check off the articles you would like to have accessible from your website. All articles are written for patients and are developed and monitored by our physician advisors. Check here to add all

- | | | |
|---|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Intravenous pyelogram | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Barium enema | <input type="checkbox"/> Interventional procedures | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Carotid artery disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> MRI Scan | <input type="checkbox"/> Upper GI |
| <input type="checkbox"/> Gallbladder diseases | <input type="checkbox"/> Mammography | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Hiatal hernia & reflux | | |

6. Most Important Topics for Search Engine Visibility

Please tell us the top 3 services you wish to promote so we can feature those on your website immediately. This is important for search engine (e.g., Google™) visibility. You can add more later.

Topic or Key Phrase	Description (the more descriptive, the better)

7. Items You Can Send

The following items will enable us to improve your website and its effectiveness. You can send them now or later, via **mail or e-mail** to the address below. Please check those you plan to send:

- | | | |
|---|--|---|
| <input type="checkbox"/> List of all practice locations | <input type="checkbox"/> Practice logo | <input type="checkbox"/> Photos - building or staff |
| <input type="checkbox"/> Doctor CV(s) | <input type="checkbox"/> Practice brochure | <input type="checkbox"/> Patient handouts or instructions |
| <input type="checkbox"/> Descriptions of services | <input type="checkbox"/> Practice letterhead | <input type="checkbox"/> Notice of Privacy Practices |

8. Medical Advisor Program (more information available at www.healthcommunities.com/advisors/)

- Joining our team of Medical Advisors qualifies you for a discount on our website services and gives you national exposure. Check this box if you are interested in becoming a Medical Advisor.

9. How Did You Hear About Us?

- Web search: Google AOL Other search engine
- Direct mail
- Ad on **radiologychannel.net**
- Link from another website: _____
- Referred by another practice: _____
- Other: _____

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10. Billing Information

Pricing: 1 practitioner \$65/month and \$350 one-time set up fee
2-4 practitioners \$75/month and \$700 one-time set up fee
5-9 practitioners \$95/month and \$1,400 one-time set up fee
Call 1.888.950.0808 for pricing for larger practices

Credit cards accepted: VISA MasterCard AMEX Discover

Select your preferred billing method: Monthly credit card Quarterly credit card

Card #: _____ Expiration: ____/____ (MM/YY)

Name on card: _____

Signature: _____ Date: _____

Credit card billing address: _____

NOTE: If needed, other billing arrangements can be made by calling us at 1.888.950.0808.

Service Agreement:

By submitting this form, you agree to be bound by the terms of the Service Agreement available at www.healthcommunities.com/agreement.shtml. Service can be cancelled at any time with 30 days written notice. The Agreement is also available via e-mail or fax upon request.

WHAT HAPPENS NEXT?

- Our team will create a website for your practice.
- You will verify the content for accuracy.
- We will launch your website on the Web and list your practice in MDLocator.
- We can continue to work together to enhance your website after the launch date, depending on your goals and level of interest.
- We will occasionally check in with you to offer ideas and assistance.

Our team is dedicated to providing superior website service and support.

Please fax all 3 pages to 413.587.0387, attn: Leslie.

- Thank you. -