EHR 24/7 Backup Disk Order Form

Please complete this form and send with payment to Office Ally via:
Fax: (360) 953-8427 or **Mail: Office Ally, Inc., P.O. Box 872020, Vancouver, WA 98687**

ORDER DETAILS:

Office Ally Username: ____ Phone: ____

Contact Name: ____ E-mail: ____

Operating System: _____ Windows (PC) _____ OS X (Mac) EHR Cancellation Date*: ___________________________

*Note: The date indicated as the "EHR Cancellation Date" will be the last date of data included in the backup disk. If not provided, data will run through the date we create the backup.

	Item	Description	# Disks	Unit Cost	Amount
	1st Disk	**Full EHR Backup Disk**: No previous EHR Backup Disks ever requested. Will contain data from all dates from the account.		**$39.95**	
	Not 1st Disk	**Subsequent EHR Backup Disk**: Previous EHR Backup Disks requested and fulfilled. Will contain data 1 year ending on backup process date, unless specific dates entered below** **Custom Start Date:** ________________ **Custom End Date:** _________________ (max. 1 year)		**$39.95**	
				Total before Sales Taxƚ	

If you have previously received a Full EHR Backup Disk and are requesting another Full one please contact Backups@officeally.com for consideration.

If an email is not received or the request is denied, your request will be updated to a Subsequent EHR Backup Disk.

Subsequent EHR Backup Disks are processed with the default time period of 1 year ending on the date the request is processed, unless Custom Start and End Dates are entered above. The Custom Start Date can be a maximum of 1 year prior to the date of this request for Subsequent EHR Backup Disk Requests.

**Dates refer to the date of the Encounters within the Account.

ƚ If the shipping address is in WA or TX, applicable Sales Tax will be added to the Grand Total once the form is received.

PAYMENT METHOD:

_____ **Credit Card:**	_____ **Electronic Check:**
Card Number: ___________________________________	Routing #: ___________________________________
Expiration Date: _________________ CCV#:___________	Bank Account #: ____________________________

If paying by Electronic Check OR Credit Card, you must also complete Payment Account Holder Information below:

Payment Account Holder Name:____(Must be EXACTLY as it reads on card/bank account)

Address: ____City:___________________________ State: ____ Zip: __________

By signing below I authorize payment for the "Grand Total" amount listed above + applicable Sales Tax via the electronic check/credit card information supplied.

Payment Account Holder Signature: ____

By signing below, I fully understand, acknowledge and agree to the following terms and conditions:

- Each copy of an EHR Backup Disk costs $39.95 + applicable Sales Tax and payment is due at the time of the request.
- First time EHR Backup Disk requests will contain all data from the account thru the date the backup is created.
- Subsequent EHR Backup Disk requests will contain 1 year of data, ending on the processing date unless a custom date range is provided.
- If I have received the full EHR Backup Disk before, but need a new full EHR Backup Disk, I must contact Backups@officeally.com for consideration.
- Standard turn-around time is 2 to 3 weeks but can take longer depending on the amount of data.

DELIVERY INFORMATION

- The EHR Backup Disk will be mailed via USPS to the Company address on file with Office Ally.
- The EHR Backup Disk will be password protected. The password will be sent via e-mail to all current Authorized Contact(s) on file with Office Ally.
  - To view the Company address and Authorized Contacts: While logged into an account with Admin Rights:
    - **Practice Mate/EHR 24/7**: Manage Office > Company Settings > Company Information
    - **Service Center:** My Settings > Admin Section > Company Information
- If the Company address or Authorized Contact e-mail address(es) on file with Office Ally are incorrect, instructions on how to update them can be found here: www.officeally.com > Resource Center > Office Ally Forms & Manuals > Account Management > Update E-Mail or Contact Address.

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Office Ally Account Owner/Authorized Contact Signature **Printed Name** **Date**