



## Single User Subscription Order Form

Type of Order: Single User Subscription \$395.00

User's Name: \_\_\_\_\_

Company: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ ext: \_\_\_\_\_

Email Address: \_\_\_\_\_

User ID: \_\_\_\_\_ Password: \_\_\_\_\_

Apps: For more information about apps, please visit [www.ahd.com/apps.html](http://www.ahd.com/apps.html)

- |  |       |       |
|--|-------|-------|
| <input type="checkbox"/> Clinical Cost Analyzer      | \$745 | _____ |
| <input type="checkbox"/> ICD9 Diagnosis & Procedures | \$245 | _____ |
| <input type="checkbox"/> MS-DRG Coding Indicators    | \$545 | _____ |
| <input type="checkbox"/> Market Analysis             | \$345 | _____ |
| <input type="checkbox"/> Profile Compare             | \$245 | _____ |
| <input type="checkbox"/> System Compare              | \$245 | _____ |

Total (\$395 subscription price + Apps): \_\_\_\_\_

### Payment Method:

- Check enclosed (make payable to "American Hospital Directory")  
 Purchase Order (please include a copy of the Purchase Order with this form)  
 Visa       Mastercard       AMEX       Discover

Card Number \_\_\_\_\_ Exp \_\_\_\_\_ Security Code \_\_\_\_\_

Cardholder's Name \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

Billing Address (If different than above) \_\_\_\_\_

Street Address

City

State

Zip

Mail : American Hospital Directory  
166 Thierman Lane  
Louisville, KY 40207

Phone: 800-894-8418  
Fax: 502-899-7738  
support@ahd.com