HARRIS COUNTY

PHYSICIAN NEWSLETTER

HCMS Harris County Medical Society

CLASSIFIED ADVERTISING AGREEMENT

COMMERCIAL AD RATES:

$165 8-line (2.5" wide x 1" high)
$320 16-line (2.5" wide x 2.25" high)
$420 24-line (2.5" wide x 3.25" high)
$567 32-line (2.5" wide x 4.5" high or 5.125" wide x 2.25" high)
$995 64-line (5.125" wide x 4.5" high)

MEMBER DISCOUNTED AD RATES:

(Must submit application – Must qualify according to policy.)

$82.50 8-line (2.5" wide x 1" high)
$160 16-line (2.5" wide x 2.25" high)
$315 24-line (2.5" wide x 3.25" high)
$425.25 32-line (2.5" wide x 4.5" high or 5.125" wide x 2.25" high)

POLICY:

- Submission deadlines are the first day of the month for that issue. Ads are accepted on a first-come, first-serve basis.
- Ad space is guaranteed only with payment. Unpaid contracts and verbal commitments only provide first right of refusal.
- Contracts must be paid in full no later than 10 days prior to publication. Ad contracts are non-refundable.
- Pricing is per issue and for the space specified, even if full space is not utilized.
- Applications for member discounted rates are subject to review and approval by HCMS administration.
- Advertising is subject to acceptance by the publisher. Advertiser assumes responsibility and liability for their ad's content.
- Advertising in the *Physician Newsletter* does not constitute an endorsement by Harris County Medical Society.

CONTACT INFORMATION:

Advertiser Name: _____ Practice/Company Name: _____

Ad Contact Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

AD INFORMATION:

Are you an HCMS member?
___ Yes ___ No

If so, are you applying for the discounted member rates?
___ Yes *(Must submit Member Discounted Advertising Application.)*
___ No

Size of ad requested:
___ 8-line (2.5" wide x 1" high)
___16-line (2.5" wide x 2.25" high)
___24-line (2.5" wide x 3.25" high)
___32-line (2.5" wide x 4.5" high or 5.125" wide x 2.25" high)
___64-line (5.125" wide x 4.5" high)

Issues wanted:

___ Jan 15	___ May 15	___ Sept 15
___ Feb 15	___ June 15	___ Oct 15
___ Mar 15	___ July 15	___ Nov 15
___ Apr 15	___ Aug 15	___ Dec 15

PAYMENT: *(Make checks payable to Harris County Medical Society.)*

_____ Credit Card _____ Check _____ Friends of the Society account

Amount: $ _____ MC / DISC / VISA / AMEX (circle one)

Card No: _____

Expiration Date: _____

Billing Address: _____

_____

Name on Card: _____

Signature: _____

Signing below is an acknowledgment and acceptance of HCMS policies and terms.

Signature: _____ Date: _____

Submit by emailing to jelolf@hcms.org or fax to 713-528-0951.

For questions, contact John Elolf at **713-524-4267, ext 244**or **jelolf@hcms.org**.