Fax completed form to: 888-894-2815

Service Agreement

Rep:_____

ORDER OPTIONS

☐ **Starter Kit $3900 plus shipping and handling ($2000 SAVINGS)**

- Three (3) 60ML Double Spin Kits
- Executive Series Centrifuge II
- Personalized Brochures (1000)

☐ Aesthetic ☐ Orthopedic
☐ Both *An additional cost of $90

- Personalized Poster (2)-(24''x36'')
- 1 hour of Business Consulting
- Patient Education Seminar Slides
- Office and Patient Forms
- Preferred Profile on www.discoverstemcelltherapy.com

ALL TRAINING IS DONE REMOTELY

Full Marketing Programs
☐ **Premium Marketing $2,500**
☐ **Premium PLUS Marketing $5,000**

Online Marketing Programs
☐ **SILVER SEM Program $1,000**
☐ **GOLD SEM Program $1,500**
☐ **PLATINUM SEM Program $2,000**

All marketing prices are per month with a term length of (6) months. **See details of marketing program and included services on next page.**

Other
☐ **Logo Design $450**
☐ **5-Page Template Website $1500**
☐ **Full Customized Website $3,500**

Select Items:	QTY:
Single Spin PRP Kits	
☐ SS-PRP-30 (30ML)	_____
☐ SS-PRP-60 (60ML)	_____
☐ SS-PRP-120 (120ML)	_____
Double Spin PRP Kits	
☐ DS-PRP-30 (30ML)	_____
☐ DS-PRP-60 (60ML)	_____
☐ DS-PRP-120 (120ML)	_____
☐ DSFC-PRP-120 (120ML)	_____
Single Spin Bone Marrow Kits	
☐ SS-BMC-60 (60ML)	_____
☐ SS-BMC-120 (120ML)	_____
Double Spin Bone Marrow Kits	
☐ DS-BMC-60 (60ML)	_____
☐ DS-BMC-120 (120ML)	_____
Adipose Concentrating Kits	
☐ ASC-35 (35ML)	_____
☐ ASC-70 (70ML)	_____
Amniotic Tissue Vials	
☐ AT-0025 (.25ML)	_____
☐ AT-0050 (.5ML)	_____
☐ AT-0100 (1ML)	_____
☐ AT-0200 (2ML)	_____
Pure Cord Blood Tissue Vials	
☐ CB-0025 (.25ML)	_____
☐ CB-0050 (.5ML)	_____
☐ CB-0100 (1ML)	_____
☐ CB-0200 (2ML)	_____

Procedure Date & Time:
_____ _____

Required for all allograft tissue orders. Please DO NOT schedule procedures on Monday and Tuesday AM

Equipment	
☐ Centrifuge	_____
☐ Microneedling Pen	_____

Orders DO NOT include S&H

TOTAL _____

CLIENT INFORMATION

Clinic Name: _____
Office Phone: _____
Physician Name: _____
Email Address: _____
Cell Phone: _____

Physician Signature: _____

Shipping Address: _____
City: _____
State: _____ Zip: _____

☐ Check box to receive emails with the latest updates and sales promotions on products and services.

CREDIT CARD AUTHORIZATION

Card Holder name (as listed on card): _____

Card Type: ☐ Visa ☐ MasterCard ☐ American Express
Credit Card Number: _____
Expiration Date: _____ Security Code: _____

Your credit card will be kept on file for future orders.
Other payment arrangements may be made with our finance dept. by emailing amy@apexbiologix.com. If invoices go past due, your card on file will be charged.

Signature: _____ **Date:** _____/ _____/ _____
Printed Name: _____

Contact Information

For Questions about Orders
Spencer Furner 801.903.1127
spencer@apexbiologix.com

APEX Biologix
5650 S Green St. Murray, UT 84123
Fax 888.894.2815