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

Select Items:	QTY:
XCELL PRP Kits	
☐XC-PRP-60 (60ML)	_____
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)	_____
Double Spin A2M Kits	
☐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)	_____

Select Items:	QTY:
Adipose Concentrating Kits	
☐ASC-35 (35ML)	_____
☐ASC-70 (70ML)	_____
Amnio Membrane Patch	
☐ AMA-1X1 (1CM^2)	_____
☐ AMA-2X2 (4CM^2)	_____
☐ AMA-2X4 (8CM^2)	_____
☐ AMA-4X6 (32CM^2)	_____
☐ AMA-7X15 (105CM^2)	_____
StemShot Vials	
☐STS-0050 (.5CC)	_____
☐STS-0100 (1CC)	_____
☐STS-0200 (2CC)	_____
StemShot	
☐STV-0100 (1CC)	_____
☐STV-0200 (2CC)	_____
Amniotic Fluid Vials	
☐AF-0050 (.5ML)	_____
☐AF-0100 (1ML)	_____
☐AF-0200 (2ML)	_____
Pure Cord Blood Tissue Vials	
☐CB-0020 (.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

Centrifuge	
☐Executive Series	_____
☐Euro Series	_____
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 kaho@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