



# Order Form

Rep: \_\_\_\_\_

Cut-Off Time for All Orders – 12 PM MST

## 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](http://www.discoverstemcelltherapy.com)

*\*ALL TRAINING IS DONE REMOTELY\**

**Select Items:**

**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) \_\_\_\_\_

**QTY:**

**Select Items:**

**Amnio Membrane Patch**

AMA-1X1 (1CM<sup>2</sup>) \_\_\_\_\_

AMA-2X2 (4CM<sup>2</sup>) \_\_\_\_\_

AMA-2X4 (8CM<sup>2</sup>) \_\_\_\_\_

AMA-4X6 (32CM<sup>2</sup>) \_\_\_\_\_

AMA-7X15 (105CM<sup>2</sup>) \_\_\_\_\_

**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) \_\_\_\_\_

**Exosomes:**

XO-0100-15 \_\_\_\_\_

XO-0500-15 \_\_\_\_\_

XO-0100-2 \_\_\_\_\_

XO-0500-2 \_\_\_\_\_

**Centrifuge**

Executive Series \_\_\_\_\_

Platinum 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

**Procedure Date & Time:**  
 \_\_\_\_\_

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