



Account Information

NEW UPDATE ADD

244 E Roosevelt Road, Lombard, IL 60148 P:(630)426-9605 F:(312)635-0108 E:sales@tianmedical.com

BILL TO:

BUSINESS OWNER/OFFICER AND COMPANY INFORMATION

MD DO DC NP _____

Name _____ Title _____

Business Name _____ Tax I.D. Number _____

Address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Ext # _____ Fax _____

Direct # _____ Email Address _____

Type of Practice _____ Website _____

* REQUIRED FIELD. MUST PROVIDE A COPY OF CURRENT MEDICAL LICENSE

PRACTICING PHYSICIAN INFORMATION

MD DO DC NP _____

*Physicians Name _____ *Physicians Email _____

*NPI # _____ *DEA Lic # _____ *Medical Lic # _____

Contact Person _____ Title _____ Department _____

Phone _____ Ext # _____ Contact Email _____

*Referral Source _____ *Name of Local Representative _____

\$650 / Box of 10 Units (Tax, shipping and handling will be applied)

PURCHASE ORDER# _____

Tx360 Order _____ Boxes

NEW REORDER CHANGE

GROUND 2nd Day Overnight

SHIP TO:

CHECK HERE IF SAME AS THE BILLING ADDRESS

Name _____ Title _____

Business Name _____ Phone _____

Address _____ Suite # _____

City _____ State _____ Zip _____

Contact Person _____ Email Address _____



Credit Application

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New Account Information & Credit Application

All New Accounts Are Required To Send A Current Copy Of their Medical License or Medical Business License

Prescription/Controlled Product Authorization: I _____ (Licensed Medical Professional) authorize the following to purchase/receive Tx360®.

Terms and Conditions: All orders will have a standard charge of UPS rates. The carrier will be UPS unless otherwise requested. If same or next day delivery is requested, the actual freight charges for this service will be added to the invoice.

Payment Terms: An invoice will accompany each order in email within 30 business days. The net invoice amount is due within thirty (30) days from date of invoice. Payments not received in accordance with our policy shall be deducted from your collections received within the month invoice was due. **Please make check payable to Tian Medical, LLC.**

Damaged Shipments: Contact Tian Medical, LLC. immediately. Please keep the original shipping box with packing materials and product for inspection, arrangements for this inspection to claim for damages and proper credit. If items are missing from your order, recheck the contents against the enclosed packing slip. If a shortage has actually occurred, you must call Tian Medical, LLC. within 24 hours in order to receive proper credit.

Returned-Goods Policy: All returns must be authorized by our customer service department in advance to receive proper credit. Any package shipped, without prior authorization will be refused upon arrival. Tian Medical, LLC reserves the right to refuse credit on any merchandise due to damages, special orders, excessive purchases, or unusual requests. Tian Medical, LLC will accept returns for established accounts based upon the following: (please note all computations will be made from the date of the invoice): 0-5 days=no charge, 5-30 days=25% restocking fee, after 30 days=no returns are accepted.

Jurisdiction and Choice of Law: This agreement shall be construed and interpreted in accordance with the laws of the State of Illinois without regard to conflict of laws, and the courts of Illinois. Illinois shall have exclusive jurisdiction in any controversy relating to or arising out of this agreement.

Signature and Guaranty: "I, the undersigned, so hereby state that the above information and any information in any documents attached hereto is true and correct to the best of my knowledge. I understand that you will retain this application. I understand and agree that this new account information form, when accepted by Tian Medical, LLC, constitutes a binding agreement between the two parties hereto, and the terms of sale set forth above hereby constitute a part of this agreement. Also, I agree to pay the collection costs and reasonable attorney's fees incurred upon default of any of the charges due and consent that such costs and fees shall be made part of any judgment rendered thereon."

My signature below is an offer of the corporation or member of a limited liability company and all indebtedness of the account holder to Tian Medical, LLC incurred hereunder.

Signed by: _____ Date: _____

Please Print Name: _____ Title: _____

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Payment Information

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ACH PAYMENT BANK TRANSFER AUTHORIZATION

Bank Name _____ Phone _____

Bank Address _____

Account Name _____ Phone _____

Address _____ Suite # _____

City _____ State _____ Zip: _____

Routing Number (9 digits) _____ Checking Account Number _____

I hereby authorize Tian Medical, LLC to initiate debit entries relating to invoices and to initiate, if necessary, credit entries and adjustments for any credits entries in error to my checking account as indicated above and the financial institution named above to credit/or debit the same to authorized account. This authority is to remain in full force and effect until written notification from me of its termination.

MUST ATTACHED A COPY OF A VOIDED CHECK

Authorized Person _____ Title _____

Authorized Signature _____ Date _____

CREDIT CARD PAYMENT AUTHORIZATION

Cardholder Name (as it appears on the card) _____

Card Type Visa MasterCard American Express Discover

Account Type Personal Corporate | Company Name _____

Credit Card Number _____ Valid Date _____ Security Code _____

Billing Address _____ Suite # _____

City _____ State _____ Zip: _____

Phone _____ Ext # _____ Email Address _____

As an authorized signer of the credit card listed above, I certify that all information is complete and accurate.

I hereby authorize Tian Medical, LLC, to collect payment for all charges relating to invoices by processing a charge to the credit card listed above. I understand that by paying with credit card, there will be an additional 3.5% service charge on total invoice amount. This authority is to remain in full force and effect until written notification from me of its termination.

Authorized Person _____ Title _____

Authorized Signature _____ Date _____