

# ANODYNE<sup>®</sup> THERAPY SYSTEM PATIENT ORDER FORM

<b>BILLING INFORMATION</b>			
<b>NAME:</b>		<b>NAME OF PERSON ORDERING</b>	
<b>ADDRESS:</b>		<b>CITY:</b>	<b>STATE:</b>
<b>PHONE NUMBER:</b> (    )		<b>FAX NUMBER:</b> (    )	<b>EMAIL:</b> _____
<b>SHIPPING INFORMATION (IF DIFFERENT THAN BILLING)</b>			
<b>NAME :</b>			
<b>ADDRESS:</b> (No PO Box)		<b>CITY:</b>	<b>STATE:</b>
<b>PHONE NUMBER:</b> (    )		<b>FAX NUMBER:</b> (    )	
<b>How Did You Hear About Anodyne?</b> <input type="checkbox"/> Web <input type="checkbox"/> Send a Friend - Patient Name _____ <input type="checkbox"/> Trade Show – Which Show? _____; <input type="checkbox"/> Ad – Which Journal? _____ <input type="checkbox"/> Published Study – Which Journal? _____; <input type="checkbox"/> Newspaper/Mag/RadioTV _____			
Product	Qty	Price	Extended Price
Home System (Model 120) – 4 Pads		\$2,995 (\$1395 for Study Participants)	
Home System Rental Trial		\$399 (Balance at 60 days if not returned)	
Soft Shoe		\$ 14.95	
		<b>Sub-total</b>	
		Sales Tax	
<b>Type of Payment</b> Bank Name _____		Shipping	No Charge
Bank Routing # (9 digits)	Bank Acct #:		
Credit Card:    VISA    MC    AMEX    DISC		<b>TOTAL</b>  <b>Patient verbally agreed to participate in Outcomes Study</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Invoice #</b> # _____	
3 or 4 Digit Security Code _____			
Number: _____ Exp: _____			
HelpCard Reference/Acct #: _____			
HelpCard Credit Limit: _____			
<b>Print Authorized Name</b>		<b>Authorized Signature</b>	
<b>Date:</b>		<b>Date</b>	
<i>For Internal Office Use Only</i>		<b>Rep:</b>	
<b>Date:</b>		<b>Received by:</b>	

**Anodyne<sup>®</sup> Therapy**

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