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 #** ______________________ ***Medical Lic #** ______________________

Contact Person ______________________ **Title** ______________ **Department** ______________

Phone ______________________ **Ext #** __________ **Contact Email** ______________________

***Referral Source** ______________________ ***Name of Local Representative** ______________________

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: ____________________

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

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 ______________________