WholeYou™

NEW CLIENT FORM

Name of Doctor: _____ Name of contact in office: _____

Name of Practice: _____ How did you hear about us? _____

Phone: _____ Fax: _____

Email Address: _____

Shipping Adrdress: _____

City, State: _____ Zip Code: _____

Billing Address (if different from above): _____

City, State: _____ Zip Code: _____

PAYMENT INFORMATION: We require a credit card on file when establishing an account with us. please select from the options below:

- ☐ I request to be charged as each case is invoiced.
- ☐ I request to be charged the total balance at the end of each month.
- ☐ I will send a check with each case.

For further information on our credit management policy, please contact the accounts receivable representative at 347-694-4884

Type of card:

Credit card#: | | | | | | | | | | | | | | | | |

Expiration Date: | M | M | / | Y | Y | This card will be charged unless a check is sent with the case.

Cardholder Name: _____ Cardholder Signature: _____

By signing above, I hereby release and authorize the use of above card to Respire Medical Holding LLC.
*We may use the personal information only to provide you with services and products.
We do not share the personal information unless it's necessary to provide you with the services and products.

Please email or fax the completed form to Respire Medical. We look forward to doing business with you!

Email info@respiremedical.com
Fax 718-643-7322

RESPIRE
breathe easy again