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. By adding your card below, you will receive $50 off your next case, and you are authorizing Respire Medical to set up your account on an Autopay. Your card will be charged when each case is invoiced. If you wish for your card to be charged at the end of each month, please check here ☐

If you would like to keep a credit card on file, please fill in the information below.

Type of card: AMEX ☐ DISCOVER ☐ MASTERCARD ☐ VISA ☐

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

Exp. date: | M | M | / | Y | Y | * this card will be charged unless a check is sent with the case.

Cardholder name: _____ Signature: _____

By signing above, I hereby release and authorize the use of the above card to Respire Medical.

*We may use the personal information only to provide you with the 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