NEW ACCOUNT FORM

Billing Information

Institution / Clinic Name: _____

Billing Contact Name: _____

Phone: _____ Fax: _____ Email: _____

Address (send invoice to): _____

City: _____ State: _____ Zip Code: _____

Shipping Information

Same as Billing Information ☐

Institution / Clinic Name: _____

Ship to Attn: _____

Phone: _____ Fax: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Physician Authorization

I am a licensed physician. I will advise patients about the potential risks and benefits of the provided procedures. I will assess all patients' medical history and medical conditions. Procedures will only be performed when my medical opinion is that the patient may benefit from the procedures.

Physician Signature: _____ Date: _____

Physician Name: _____ Admin Contact: _____

Phone: _____ Fax: _____ Email: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Admin Contact: _____

Phone: _____ Fax: _____ Email: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Admin Contact: _____

Phone: _____ Fax: _____ Email: _____

Cytonics Corporation

555 Heritage Drive, Jupiter, FL 33458

P: 561-575-4451 F: 561-257-0782 E: Info@Cytonics.com

For more information visit: www.Cytonics.com

FOR USE BY CYTONICS PERSONNEL ONLY

Account #: _____