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| Client Name: | Submitted By: | Date: |
| Address: | City: | State/Zip: |
| Email: | Home Phone: | Cell Phone: |

Shoulder L R Neck / Cervical PRICE

Knee L R Mid-Back / Thoracic

Hip L R Low-Back / Lumbar

Hand/Wrist L R

Foot/Ankle L R

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_

LOCATION: \_\_\_\_\_\_\_\_\_\_ In home \_\_\_\_\_\_\_\_\_\_Office Visit $\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Special Instructions: | |
|  | |
| **PAYMENT INFORMATION**  \_\_\_\_\_\_\_\_CHECK \_\_\_\_\_\_\_\_FINANCE \_\_\_\_\_\_\_\_CREDIT CARD    CC #\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP\_\_\_\_\_\_\_\_\_\_ CVV\_\_\_\_\_\_\_  \*By entering credit card information above, Customer(s) hereby authorizes Regenlife to charge the credit card as indicated. ***PLEASE VERIFY THAT DAILY AND SPEND LIMITS ARE NOT EXCEEDED & correct billing address is listed above.*** | **TOTAL $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| I/We hereby acknowledge that no guarantees have been made and that the practice of regenerative medicine is not an exact science and that the treatment of any ailment may involve risks.  I/We agree and understand that this Agreement constitutes the entire understanding between the parties, and that there are no verbal understandings changing or modifying any of the terms of this Agreement once payment is made.  Authorized Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Authorized Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

*\*\*If the procedure is not 50% or more effective at 12 months, I may choose to repeat the procedure for 50% of the total* ***current*** *cost.*

*Any additional body parts/areas are not included if you have not been previously injected.*

***Office Use Only:*** Case #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recom Amount: \_\_\_\_\_\_\_\_ Order #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Seminar Town\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**