PEAKS & PLAINS MEDICAL, INC.

Fax to: 1-800-886-1747

Phone : 1-800-585-4201

New Resident

PRIVATE PAY

Name:	**Birthdate:**	**Male: Female:**
Facility Name		**Type:**
Address:	**City**	**State & Zip code**
Telephone	**Cell Phone**	**Height: Weight:**
Facility Contact Name:	**Telephone:**	**Fax:**
Email Address for shipment Confirmation:		
DOES CLIENT HAVE A LATEX ALLERGY?	**YES _____ NO _____**	

I agree to be responsible for any charges for supplies ordered for this person. I understand that all bills must be paid 30 days from the date of the invoice. I have received a copy of the Return Policy and the Protocol for Resolving Complaints.

In the event that legal action must occur for collection purposes, the venue for such or any action shall be resolved in Spokane County, State of Washington. Should a dispute arise, the action shall be resolved by mandatory arbitration. In the event of any breach of this Contract, the party responsible for the breach agrees to pay reasonable attorney's fees and costs, including costs of service of notices, incurred by the other party. In the event that an invoice is not paid within 30 days from the date of the invoice, interest shall be charged at a rate of 1 ½ % per month (18% per annum).

X_____ _____

Signature of Patient or Person Authorized to Sign for Patient DATE Sales Person

(Must have POA or Authority in Writing to Sign on Behalf of the Patient.)

E-Mail Address: _____

Bill to, if different from above: _____Tel_____

ADDRESS_____

Street City State Zipcode

ITEM	PRODUCT DESCRIPTION/SIZE	Per Day	Month