



**Amjo Corp**  
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# Physician Approval Patient Order Form

## Description of equipment being purchased and value(s)


**Total Price:** \_\_\_\_\_

### TERMS:

- Units: Full payment at time of order, or at least 50% deposit upon approved credit. The balance is due upon receipt of invoice. A finance charge of 1% per month is added to any unpaid balance.
- Lamps: Full payment is required with order.
- Warranty: Foldalite-B, PANOSOL II and HAND/FOOT II: 3 years Parts and Labor, Handisol NB 1 year Parts & Labor. Lamps – 90 days.
- Shipping: Panosol II, Hand/Foot, HandiSol and Dermalight shipped FOB Destination. All other products shipped FOB Origin. Charges are pre-paid and added to invoice. Outside continental United States shipped freight collect or prepayment with purchase.
- Returns: No returns without prior authorization. Returns are subject to a re-stocking charge.
- Service: Service is performed on your premises when applicable.
- Financing: Contact Amjo Corp for details.
- Insurance: Amjo Corp provides FREE insurance reimbursement processing. Purchaser is responsible for any and all charges remaining. Deposit required.

### PHYSICIAN APPROVAL: (A separate prescription can be provided in lieu of completing this section)

I authorize my patient \_\_\_\_\_, to purchase the product(s) described above. This patient has been instructed to consult me on a regular basis for follow-up exams and is aware of the treatment procedures with this/these product(s). The manufacturer will supply a manual for each unit and/or meter purchased.

#### Physician Data:

Signature \_\_\_\_\_ M.D.  
 Name: \_\_\_\_\_ Phone(\_\_\_\_-\_\_\_\_-\_\_\_\_)  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 U.P.L.N.# \_\_\_\_\_ My preference is [  ] UVA [  ] UVB [  ] UVBNB light

### PATIENT DATA:

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_-\_\_\_\_-\_\_\_\_)  
 Street: \_\_\_\_\_ Work Phone: (\_\_\_\_-\_\_\_\_-\_\_\_\_)  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_  
 Position: \_\_\_\_\_ No. Yrs. \_\_\_\_\_  
 Social Security No. \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Visa/MC/Am Ex/Disc No. \_\_\_\_\_ Expires: \_\_\_\_\_ Amount of check or credit card: \$ \_\_\_\_\_

I understand the above and completed all statements as accurately as possible. I further understand that failure to comply with my physician's instructions or to schedule periodic follow-up exams will negate my physician's responsibility for adequate patient care in the use of this product.

Authorized Signature \_\_\_\_\_