MILE HIGH ORTHOTICS LAB

CLIENT INFORMATION SHEET

OFFICE NAME: _____

DOCTOR'S NAME(S): _____

BILLING CONTACT: _____

BILLING PHONE NUMBER: _____

BILLING EMAIL ADDRESS: _____

SHIPPING ADDRESS: _____

CLINIC PHONE NUMBER: _____

CLINIC EMAIL ADDRESS: _____

CLINIC FAX NUMBER: _____

CLINIC WEBSITE: _____

All Orthotic accounts are Net 30 from date of invoice,
Any orthotic account that is paid in full by the 10th of the month shall receive a 5% discount from the amount to be applied to the following month's balance.
This discount does not apply to past due accounts.

All AFO/Brace Accounts are Net 15 from date of invoice.

I have read the above information and agree with the terms.

Authorized Personnel Name: _____

Authorized Signature: _____

Date: _____

Sales Representative: _____

4970 Monaco St, Unit A
Commerce City, Colorado 80022
Phone: (866) 710-4880 or (303) 289-1534
Fax (303) 288-3687

SAVE PRINT RESET