Dear Medical Professional,

To receive reduced pricing on all of BSI's quality rehabilitation and therapy supplies, please print the **"APPLICATION FOR REDUCED MEDICAL PRICING"** and fax the completed form to Toll-Free: 1-888-809-1645. Your application will be reviewed and once verified, a customer service representative will be in contact with you via email to provide you with the discounted pricing.

After this initial application process, BSI provides three (3), easy purchasing options:

1) When the customer service representative contacts you, they will provide your clinic a **Special Discount Code for online purchases** *at either www.flextend.com or www.repetitive-strain.com. Once your* information is verified and your account is established, you can then purchase online and apply the discount code for savings on all purchases. Note that the discount code is entered at the end of the ordering process and the discount will be calculated at that time. Items are generally shipped within 48 business hours. You will be contacted if we cannot ship your order within the 48-hour time frame. *NOTE:* BSI advises that you order on-line for all purchases containing less than 1-dozen units of a particular item. For orders of 1-dozen or more of the same item, you will receive an additional price break, which our on-line shopping cart is not able to accommodate.

2) **Once your account has been established, Phone Orders are simple and easy! Call BSI Toll-Free 1-888-274-5444 in the US and Canada**, or dial (541) 938-7163 outside those areas, to purchase any items you may need. BSI will simply email you an invoice that will need to be paid via PayPal prior to BSI mailing your shipment.

3) **Fax orders are quick and simple. Print off our fax order sheet, fill it out completely and Fax order to BSI at Toll-Free: 1-888-809-1645.** You may order by Fax for any size purchase, but keep in mind, all first time phone or fax orders must be prepaid unless you already have an established on-line buying history with BSI.

IMPORTANT: We offer generous volume discounts. When ordering in volume, it is recommended you order by phone or fax to receive best possible discount.

APPLICATION FOR REDUCED MEDICAL PRICING

Date_____

Firm Name_____**Tax ID:**_____

Facility Type- ☐ **Medical** ☐ **Physical Therapy** ☐ **Chiropractic** ☐ **Other-***explain*_____

_____

Physician / License Number_____

Description of Business_____

***BILLING* Address**_____

City_____ **State**_____ **Zip**_____

***SHIPPING* Address**_____

City_____ **State**_____ **Zip**_____

Phone_____ **Fax:**_____ **Email:**_____

At present location since (date)_____ **Year established**_____

REFERENCES:

Name_____ **Phone**_____

Address_____ **City**_____ **State**____ **Zip**_____

Name_____ **Phone**_____

Address_____ **City**_____ **State**____ **Zip**_____

Name_____ **Phone**_____

Address_____ **City**_____ **State**____ **Zip**_____

Name_____ **Phone**_____

Address_____ **City**_____ **State**____ **Zip**_____

BANKING INFORMATION

Bank_____ **Account #**_____

Branch_____ **Phone**_____

Address_____ **City**_____ **State**____ **Zip**_____

Additional information_____

_____

Terms and Conditions- I/We agree to pay my/our account in accordance with the regular terms of Balance Systems, Inc., On-Line Orders: Paid in full via credit card at time of purchase. Phone Orders: All first time orders must be pre-paid / NET 30 DAYS on all proceeding orders. All shipments are F.O.B. Balance Systems, Inc... I/We understand that any balance not paid within those terms will be assessed a 2% FINANCE CHARGE. I/We understand and agree that the purpose of the late charge is to induce payment of the obligation. I/We also agree to pay, in the event payment shall not be made when due, all costs of collection, and I/We further agree that, in case suit is instituted to collect any amount due, to pay such additional sums as the court may adjudge reasonable as attorney's fees.

APPLICANT'S SIGNATURE ATTESTS ABILITY AND WILLINGNESS TO PAY INVOICE IN ACCORDANCE WITH ABOVE TERMS.

_____ **X**_____ _____

Firm Name **Authorized Signature** **Authorized title**

The above information is for the purpose of obtaining credit and is warranted to be true. By signing above, I/We hereby authorize Balance Systems, Inc. to investigate the references listed pertaining to my/our credit and financial responsibility. I/We understand all information is strictly confidential.

Fax Application To: 888-809-1645

Balance Systems, Inc., 325 W. Broadway Ave., Milton Freewater, OR 97862

BSI ORDER FORM

How You May Place Your Order...

By Phone: (541) 938-7163 or 1-888-274-5444
By Fax: 1-888-809-1645
On-line: www.repetitive-strain.com

Checks/ Make Payable to:

Balance Systems, Inc.
1644 Plaza Way, Ste. #317
Walla Walla, WA. 99362

Ship to:

Your Name_____ Clinic / Company _____

Billing / Shipping Address_____

City _____ State ____ Zip _____

Province/Country (if not US) _____

Phone (daytime/business) _____ (evening/other) _____

Fax _____ E-mail Address_____

Product / Item No.	Description	Unit Price DropShip / Inventory	Units	Total Price	List Price - MSRP
S1961-06R2A	**FLEXTEND® *UNIVERSAL* GLOVE**				
UFXXL-08	FLEXTEND XX-Large				$120
UFXL-08	FLEXTEND X-Large				$120
UFL-08	FLEXTEND Large				$120
UFM-08	FLEXTEND Medium				$120
UFS-08	FLEXTEND Small				$120
UFXS-08	FLEXTEND X-Small				$120
UFXXS-08	FLEXTEND XX-Small				$120
FLX-CD	FLEXTEND Computer CD. *All 15 Exercise Programs & Videos included.*				$20.00
FLXTFT-504	FLEXTEND TFT-Kit For Trigger Finger rehab.				$12.95
FLXACKIT	FLEXTEND AC-KIT For shoulder, chest and back rehab.				$39.95
				TOTAL DUE	
				$	

NOTE: Each FLEXTEND® System comes with 1- Instruction Chart containing four exercise programs – Carpal Tunnel, Trigger Finger, Tennis Elbow and Grip Strength. The customer may download all of the additional exercise programs for FREE in the shopping cart under "EXERCISE PROGRAMS".

Shipping & Handling:

Drop Ship = $9.95 first item + $2.50 ea. Additional.
Inventory = Please Call for Quote

PAYMENT METHOD (NET-30 is Available to Approved Vendors Only.)

NET 30:_____ Check #: _____ (allow 10 business days for processing) Money Order _____

*BILL MY: Visa _____ MasterCard _____ American Express _____ Discover _____

* *CC Payments: An Invoice will be emailed to you for all credit card orders as they are processed through PayPal.*

Signature: _____Clinic Name:_____