Allergy Associates
Allergy alternatives made simple
1-800-584-0526
www.aamsus.com

New Account Form - SCIT

Subcutaneous Immunotherapy - (please print clearly)

Practice Information:

- Practice Name: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone #: _____ Fax #: _____
- Email Address: _____
- Supervising Practitioner's Name: _____
- Supervising Practitioner's Signature: _____
- Supervising Practitioner's License #: _____

Order Information:

- Credit Card Type: □ Visa □ MC □ Amex □ Discover □ Other
- Name on Credit Card: _____
- Address Associated with Credit Card: _____
- Zip Code Associated with Credit Card: _____
- Credit Card #: _____Exp Date: ____ Sec. Code: _____

Shipping Information: □ Same as above ***OR*** □ Use shipping address below:

- Address: _____
- City: _____ State: _____ Zip: _____

Please send your New Account Form to:

Via Fax: 1-800-309-7905 **Via Email**: sales@aamsus.com

NOTE: Your email information is used for order confirmations, new product information and AAMS communications, it will NOT be shared with 3rd party vendors or other outside sources. A paid invoice receipt will be emailed after placement of your order for your records.

Terms and Conditions

Payment Terms: Credit Card Charged on Shipment: I authorize Allergy Associates Management Services, LLC. to charge my credit card for any and all purchases by the Company or Individual listed above related to management services and facilitation of patient immunotherapy prescriptions. I understand that my credit card will be charged when the goods orders are placed for formulated product unless other written arrangements have been made.

Credit Collection Agreement: After 90 days and if the matter is placed with an attorney or collection agency for collection, whether or not suit is brought hereon to enforce payment, we agree to pay all costs of collection including a reasonable attorney's fee.

In consideration of an extension of credit, (we) the undersigned, assume full responsibility for bills incurred as a result of this application.

I certify that all of the information on this form is correct. I fully understand your credit terms and agree for the proper payment in consideration of the credit terms. I understand that the product manufacturer or compounding pharmacy will update account information on our practice annually and we will be required to fill out the customer account information form when requested.

If you are tax exempt, we must have a copy of your exemption certificate for our files.

A photographic or facsimile of this authorization may be deemed to be the equivalent of the original and may be used as a duplicate original

This form will be valid and kept on file until we receive written request to remove the credit card information. The portion of this form containing credit card number and security code will be destroyed upon entering into our secure customer account database.

Business Name: _____

Printed Name: _____

Signed: _____ Title: _____

Date: _____

Pricing of Immunotherapy Treatment Sets for 2020 are as follows:

Each Treatment Set: ..... $230.00 USD
4 vials (5mL each), with 1 of each of the following dilutions:
1:100,000, 1:10,000, 1:1,000 and 1:100
(regardless of the number of antigens included):

Each Maintenance Vial: ..... $230.00 USD
1 vial (10mL), undiluted, 1:100:
(regardless of the number of antigens included):

Type of business: Medical Practice Pharmacy Distributor

Healthcare Institution Other _____

License information (authorizing purchase of prescription products):

☐ Medical Doctor ☐ Pharmacy ☐ Distributor/Wholesaler/Manufacturer

☐ Healthcare Institution

Name of licensee: _____

State of licensure: _____ License number: _____

Staff authorized to order prescription products:

_____

_____

Name of person authorizing prescription product purchases:

_____

Signature _____ Date: _____

Contact info: (phone, fax, email): _____