



Albeck Medical

A Subsidiary of H & L Medical Specialists, Inc.

FAX ORDER FORM

BILL TO:		SHIP TO:	
Name:	_____	Name:	_____
Address:	_____	Address:	_____
City:	_____	City:	_____
State:	_____	State:	_____
	Zip: _____		Zip: _____
Phone:	_____	Phone:	_____

Quantity	Item Description	Size/Color	Unit Price	Total
<i>Please contact us for Shipping Charges</i>			Subtotal	
<i>Please add tax only if in AZ</i>			Shipping	
			Tax	
			Total	

Payment Information	Shipping Information
<input type="radio"/> Visa <input type="radio"/> Mastercard <input type="radio"/> AmEx <input type="radio"/> Discover Credit Card No.: _____ Name (As it appears on card): _____ Expiration Date: _____ CVV#: _____ Card Holders Signature: _____	Please select your shipping method: <input type="radio"/> Overnight <input type="radio"/> 2 nd Day Air <input type="radio"/> Ground <input type="radio"/> Other _____

Patient Information						
Patient Name: _____						
Age:	_____	Weight:	_____	Height:	_____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

Please fax completed form to: 480-945-4372