

Distributor: \_\_\_\_\_  
Name: \_\_\_\_\_  
Email: \_\_\_\_\_  
Cell: \_\_\_\_\_

## Customer Information

PROVIDER NAME:

TAX ID#:

PRACTICE NAME:

SHIP TO ADDRESS:

CONTACT NAME:

CONTACT PHONE:

TELEPHONE:

FAX:

EMAIL:

HOW DO YOU BILL?

Group NPI #:

Individual NPI #:

BILL TO ADDRESS:

AP CONTACT NAME:

AP PHONE:

AP EMAIL:

## CLAIMS PROCESSOR INFORMATION

CONTACT NAME:

EMAIL:

TELEPHONE:

**Fax Form to: 800.886.8266 or email to: [orders@extremitycare.com](mailto:orders@extremitycare.com)**

This Service Agreement (the “Agreement”) is entered into as of this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
(the “Effective Date”) between Extremity Care LLC (“Extremity Care”) and (“Customer”).

Provider Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

## Background

The Customer wishes to purchase and Extremity Care has agreed to sell to Customer human cell and tissue products, subject to the following terms.

Now, therefore, the parties agree as follows:

1. **Product Prices.** Product means the human cell and tissue products offered by Extremity Care as described in Schedule A, as such Schedule may be modified from time to time. The Invoice Price for each Product is the price stated for that Product in Schedule A.
2. **Insurance Verification.** Customer agrees to utilize Extremity Care’s Insurance Verification Request form (IVR) prior to ordering and using Products.
3. **Order Fulfillment.** After Customer submits an IVR and receives confirmation of patient’s benefits, the Customer places an order and Extremity Care accepts the order and generates an invoice, which will reflect that the Customer has agreed to purchase the Products identified on the invoice and the terms of the purchase. Extremity Care shall, on Customer’s behalf, promptly pack and ship the Products identified on the invoice for delivery to the Customer using second-day delivery. Extremity Care shall provide delivery status information from the carrier to the Customer for shipment.
4. **Product Usage.** After receiving Product(s), Customer will treat the patient as medically necessary. After each treatment, Customer will complete the Extremity Care Graft Log and fax such Log to Extremity Care. Customer and Extremity Care acknowledge that use of any Product is at the sole discretion of the treating provider, pursuant to his or her professional medical judgement.
5. **Disposal.** If for any reason the allograft is opened and not used; it should be disposed of properly. **Document the reason for the non-use of the allograft, indicate the disposition of the tissue on the allograft return card, and return the card to Extremity Care LLC.** Allograft disposal shall be in accordance with local, state, and federal regulations for human tissue. **Product that cannot be used because it is defective** or if it does not meet the specification requirements, **should be returned to Extremity Care LLC** following appropriate return procedures described below.
6. **Return.** In alignment with the regulatory requirements outlined in 21 C.F.R. 1271.265(f), Extremity Care establishes this return policy for Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps). This policy adheres to the standards set forth by the American Association of Tissue Banks (AATB) and regulations set forth by the FDA’s guidance for good tissue practice, and Customer agrees to comply with this return policy and its attestations as set forth herein. Returns will **NOT** be accepted if the original container has been opened, compromised or if the allograft has exceeded expiration date. If for any reason the allograft must be returned, the process set forth herein must be followed by Customer and Customer attests as set forth herein. Customer must promulgate a policy which either authorizes or prohibits the return of tissue in its original, unopened container. This policy must be clearly established and adhered to prior to any requested returns. Prior to requesting a return, Customer shall conduct a thorough examination of the integrity of the container, packaging, and labeling of the tissue for evidence of contamination, tampering, or any other compromise to the tissue’s quality or safety. Under no circumstances shall tissue that exhibits any signs of contamination, tampering, mishandling, or failure to maintain the requisite storage temperatures be eligible for return. The allograft to be returned shall be in its original packaging, which must remain unopened and free from any tampering to ensure the tissue’s integrity and suitability for return. The tissue must have been consistently maintained in conditions that align with the manufacturer labeled storage requirements to ensure the tissue has been maintained in an environment conducive to preserving its quality and safety. The labeling on the tissue must be clear, legible, intact, and free from any form of defacement or alteration to allow verification of the tissue’s identity and

ensure its traceability. The return shipment of the tissue must be executed using an overnight shipping service scheduled between Monday and Thursday to ensure timely and sufficient delivery. The shipping box and return label provided must be used for this purpose to facilitate a secure and traceable return process. By executing this Agreement, and prior to returning any tissue product to Extremity Care consistent with and pursuant to this Agreement, Customer **attests as a condition of any and all returns of tissue products**, that it (i) has not opened, tampered with, damaged and/or contaminated any tissue product, including its packaging; (ii) has not transferred ownership or location from original receipt from Extremity Care; and (iii) consistently has stored the tissue product, as packaged, subject to the requested return in the recommended environment as set forth on the label. Customer's attestation for each such requested return as set forth in this Agreement is crucial to ensure that the product was stored and handled in compliance with protocol. In compliance with AATB Standards 14th Edition, Section H4.100, Temperature Records, relating to the handling of tissue necessitating controlled environmental temperatures, Customer **attests as a condition of any and all returns**, that Customer has consistently maintained the tissue product subject to the requested return, as originally packaged, at the prescribed and labeled temperature settings. This attestation by Customer is imperative to ensure the integrity and sterility of the tissue, and adherence to this standard is essential for legal and ethical compliance in tissue handling and storage. Customer, upon requesting a return label from Extremity Care, shall provide information to Extremity Care about the specific reason for the return of the tissue (such as surplus requirements, order errors, or any other relevant factors that necessitated the requested return), which will then be documented in writing and confirmed in an email from Extremity Care to Customer with the return label. By signing this Agreement, Customer **attests** that only tissue maintained as set forth herein, including at the required storage temperatures, and handled as attested herein, will be returned pursuant to this Return process.

Upon receipt by Extremity Care, and prior to acceptance of any return by Extremity Care, the returned allograft must be in good condition to ensure that the tissue has not been compromised during transit and is suitable to be returned to inventory.

7. **Invoices & Payment.** Following each order, Extremity Care will develop and deliver an Invoice to Customer that identifies the Invoice Price of the Products ordered and not yet paid by the Customer, and any other charges or credits on the Customer's account. Customer agrees to pay Extremity Care the balance due amount stated in each Invoice within sixty (60) days of the date of the Invoice. Customer agrees to provide Credit Card Authorization for payment of all invoices.
8. **Miscellaneous.** This Agreement contains the entire agreement between the Parties concerning the subject matter hereof and is governed by Pennsylvania law. This agreement may be amended or modified only by a written agreement signed by both parties.

Executed as of the Effective Date.

Extremity Care LLC

\_\_\_\_\_  
Signature (*Cursive*)

\_\_\_\_\_  
Name (*Print*)

\_\_\_\_\_  
Customer Signature (*Cursive*)

\_\_\_\_\_  
Customer Name (*Print*)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Company Name

### Product and Price

\*Discount Percentage/Special Pricing: \_\_\_\_\_

	SKU	Product Description	Size	Units	List Price	ASP	Extended Price
Coll-e-Derm™ <b>Q4193</b>	ADT22M	Coll-e-Derm™, Acellular Dermal Matrix, Meshed	2x2cm	4	\$7,800.00	\$8,268.00	
	ADT23M	Coll-e-Derm™, Acellular Dermal Matrix, Meshed	2x3cm	6	\$11,700.00	\$12,402.00	
	ADT24M	Coll-e-Derm™, Acellular Dermal Matrix, Meshed	2x4cm	8	\$15,600.00	\$16,536.00	
	ADT44M	Coll-e-Derm™, Acellular Dermal Matrix, Meshed	4x4cm	16	\$31,200.00	\$33,072.00	
	ADT46M	Coll-e-Derm™, Acellular Dermal Matrix, Meshed	4x6cm	24	\$46,800.00	\$49,608.00	
	ADT48M	Coll-e-Derm™, Acellular Dermal Matrix, Meshed	4x8cm	32	\$62,400.00	\$66,144.00	

## CREDIT CARD AUTHORIZATION FORM

Please sign and complete this form to authorize Extremity Care LLC to apply charges to your credit card listed below. By signing this form, you grant Extremity Care LLC permission to charge the credit card below for each graft shipped after 60 days. This one time payment will not be applied without email approval from the providers office.

Please complete the information below:

I \_\_\_\_\_ (Full Name) authorize Extremity Care LLC to charge the credit card account indicated below 60 days after the shipment of all Coll-e-Derm™ product(s).

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### Credit Card Authorization

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PROVIDER NAME: \_\_\_\_\_

CREDIT CARD TYPE: ☐ AMEX ☐ VISA ☐ MASTERCARD

CREDIT CARD NUMBER: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_ CVV: \_\_\_\_\_

EMAIL: \_\_\_\_\_

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SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company so long as the transaction corresponds to the terms indicated in this form. Credit card payments will incur a processing fee of 3.5% per transaction.