ExtremityCare®
in partnership with ParametricsMedical

completeFT™

Customer Onboarding - Service Agreement

MAC_____

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

ExtremityCare®
in partnership with ParametricsMedical

completeFT™

Service Agreement

This Service Agreement (the "Agreement") is entered into as of this _____ day of _____, 20____ (the "Effective Date") between Extremity Care LLC ("Extremity Care") and

Provider Name: _____

Office Address: _____

_____

("Customer").

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**. 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, a return authorization must be obtained from Extremity Care LLC prior to shipping the allograft. It is the responsibility of the healthcare institution or healthcare provider returning the allograft to adequately package and label the allograft for return.
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:_____

Print Name:_____

Title:_____

Company Name:_____

ExtremityCare®
in partnership with ParametricsMedical

completeFT™

Schedule A

Product and Price

Discount Percentage/Special Pricing: _____

	Catalog #	Product Description	Units	List Price	ASP	Extended Price
completeFT™ **Q4271**	EFT22	completeFT™ Placental Allograft Membrane 2x2cm	4	$6,996.00	$6,996.00	
	EFT24	completeFT™ Placental Allograft Membrane 2x4cm	8	$13,992.00	$13,992.00	
	EFT44	completeFT™ Placental Allograft Membrane 4x4cm	16	$27,984.00	$27,984.00	
	EFT36	completeFT™ Placental Allograft Membrane 3x6cm	18	$31,482.00	$31,482.00	
	EFT48	completeFT™ Placental Allograft Membrane 4x8cm	32	$55,968.00	$55,968.00	

ExtremityCare®
in partnership with ParametricsMedical

completeFT™

Credit Card Authorization

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 completeFT™ product(s).

Credit Card Authorization

PROVIDER NAME:_____

CREDIT CARD TYPE: ❑ AMEX ❑ VISA ❑ MASTERCARD

CREDIT CARD NUMBER: _____ EXP. DATE:_____CVV:_____

EMAIL: _____

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.

Extremity Care LLC • 555 E North Lane, Ste 5000, Bldg D • Conshohocken, PA 19428 • www.extremitycare.com

CUSTOMER SERVICE 1.888.694.6694 | customerservice@extremitycare.com
BILLING 1.844.484.CPAC (2722) | orders@extremitycare.com
FAX 1.800.886.8266