

**BILL/SHIP TO:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

**ORDER:**

Selection	Item	Price
<input type="checkbox"/>	25 pack	\$12
<input type="checkbox"/>	50 pack	\$21
<input type="checkbox"/>	100 pack	\$36
	USPS Flat Rate Shipping	\$ 10.20
	<b>Grand Total</b>	<b>\$</b>

**PAYMENT:**

Card Type American Express Discover MasterCard VISA

Credit Card No. \_\_\_\_\_

Exp. Date (MM/YY) \_\_\_\_\_

Name on Card \_\_\_\_\_

Billing Address if different from above

\_\_\_\_\_

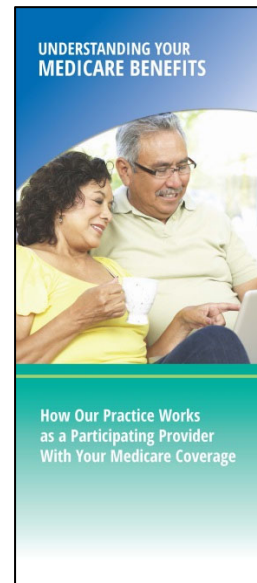
Signature \_\_\_\_\_

1. Be sure you selected your provider status.
2. Fax completed order to: (800) 974-3479 or
3. E-mail to [info@customchirosolutions.com](mailto:info@customchirosolutions.com)

I would like to receive compliance e-mail updates from Custom ChiroSolutions.

Please select version:

Participating Provider



Non-Participating Provider

