



(Office Only) MRN: _____

Phone (801) 226-3600 • Fax (801) 224-3811
Orem: 159 North 400 West, Suite B-8, Orem, UT 84057

PATIENT NAME: _____
DOB: ____/____/____ AGE: _____ SEX: M / F
DATE: ____/____/____

Payment to be made at the time of order.

Please allow 2 weeks for serum refills and delivery.

Bottle: _____ Dilution: _____ Dose: _____
Bottle: _____ Dilution: _____ Dose: _____
Bottle: _____ Dilution: _____ Dose: _____

Number of Vials: One Vial/\$120 per month Two vials/\$240 per month Three vials/\$360 per month
Number of Months: _____ (6 vials maximum)

Charge: \$ _____

Office Pick-up. If you select office pick-up, but are unable to do so, and need us to mail it out instead, we will require a written statement mailed to us. Please initial _____.

Mail Out to (\$25 S&H due prior to shipment):

*There are risks to mailing the serum, as the serum may degrade in temperature extremes, thus rendering the serum less effective.

*Please note that we are also not responsible for lost or damaged serums in the mail.

Signature: _____ Date: ____/____/____
Phone: (____) _____ - _____

Joshua Burkhardt, DO • Tammy Jacobs, MD