Corporate
U.S and International Headquarters
326 Main Street
Harleysville, PA 19438
Toll Free: 800.270.7074
Tel: 215.256.9000
Fax: 215.256.9006
orders@advanced-orthopaedics.com

Sales & Marketing
Executive Offices
19 Shelter Cove Lane
Suite #207
Hilton Head, SC 29928
Tel: 843.682.4400
Fax: 843.682.4401
info@advanced-orthopaedics.com

Logistics
Warehouse
5542 Columbia Blvd
Bloomsburg, PA 17815

EMAIL TO info@advanced-orthopaedics.com
FAX TO 215.256.9006

NEW ACCOUNT SETUP FORM

Note: This application must be returned before any products are shipped

Business Information / Bill To:

Firm Name _____

D/B/A _____

Address _____

City _____ ST _____ ZIP _____

Owner (s) / Principal (s) _____

Purchasing Contact _____

Email _____

Phone _____

Ship To: Same as Bill To ☐

☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ LLC

Name _____

Address _____

City _____ ST _____ ZIP _____

Acct. Payable Contact _____

A/P Phone _____

A/P Fax _____

A/P Email _____

Tax Information

Is this business tax exempt? ☐ No ☐ Yes *(if yes, check one of the boxes below)*

Tax ID_____ DNB #_____

☐ **Product purchaser for release only.** Please provide copy of your resale certificate

☐ **Charitable or nonprofit organization exempt from sales and/or Use Tax**. Please provide copy of exemption certificate.

☐ **Product to be purchased is tax exempt in:** Please provide copy of exemption certificate. **State** _____ **County** _____

Credit Card Information *(to be placed on file)*

Name on Card _____ ◯ VISA ◯ Mastercard ◯ AMEX

Card # _____ Exp. Date 1_____ / _____ / _____
Month Year CCV Code

Account Terms

Warranty: We guarantee complete satisfaction on all our products. If you experience issues with one of our products, please contact your AO Sales Rep or call Customer Service. **Return Policy:** Before returning any product, please call our Customer Service department for an RMA. All returns must be accompanied by an RMA. No returns will be accepted after 30 days from the date of invoice. All returns are subject to a 25% restocking fee. **Past Due Balance Policy:** I (we) agree that our balance shall be computed at the rate of 1.5% per month (18% APR) on the unpaid balance. I (we) authorize Advanced Orthopaedics, Inc. to charge the unpaid balance, if not paid for by the terms of my (our) account, using the credit card on file. In the Event that is becomes necessary to assign the account for collections, I (we) agree to pay all collection costs and/or if legal action (or appeal) is required, I (we) agree to pay all attorney fees and costs that are incurred. If a suit is brought, venue may be laid in the county and state of the creditor's choice. For past due balances paid using a credit card, I (we) authorize a 5% credit card surcharge.

I (we) have read the above terms and conditions and agree to abide by them and Certify that the information given above is complete and accurate.

Executed on this _____ day of _____ , 20____

Authorized Signature _____

Printed Name _____

Submit

Internal Use Only

Rep Code _____ Product Packaging _____ Freight _____ Private Label ☐ Yes ☐ No