NEW CUSTOMER ACCOUNT APPLICATION PROCESS

PHYSICIAN ACCOUNT:

- Social Security #, bank information & credit references required
- Physician's **MEDICAL LICENSE** with expiration date
- Physician's signature and printed name in space provided
- **PREPAY ACCOUNTS** – Social Security #, bank information & credit references **NOT** required
- **CORPORATION OR PARTNERSHIP** - Must provide Tax ID number, name of corporation, signature of Financially Responsible Person & a Personal Guarantor. Please do not include title with signature

HOSPITAL, SURGERY CENTER ACCOUNT, ENDO SUITE:

- If attaching credit application sheet- you must enter name, address and appropriate signature on **our** application
- Applicant's signature - Financially Responsible Person - in space provided - CEO, CFO, COO
- **Medical Facility License issued by the State Department of Health**
- Tax Exemption Certificate (If applicable)
- **PREPAY ACCOUNTS** – bank information & credit references **NOT** required

RETURN COMPLETED APPLICATION:

- **By Fax: (636) 333-1011**
- **By Email: info@inxmedical.com**
- **By Mail:** inx Medical, 1819 Clarkson Rd., Suite #206 Chesterfield, MO 63017

Please allow 3 to 7 days for processing of your application. We will fax or email you your account number. Keep your account number secure to avoid unauthorized use of the account.

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. Pending approval of credit information and verification of the medical license, we reserve the right to deny any application or put the account on a C.O.D. or PREPAY basis.

inx Medical

I. PHYSICIAN'S ACCOUNT

Physician's Name:	SS# (If individual account):
Physician's License # and License State:	
Type of Business: ◯ Individual ◯ Partnership ◯ Corporation - TAX ID:	
Corporation Business Name and DBA:	

*** PERSONAL GUARANTOR (IF CORPORATION)**

Print Name (no title):	Signature (no title):
Address (street, city, state, zip):	

II. HOSPITAL/SURGERY CENTER ACCOUNT

Facility Name:	Tax-exempt ID #: (attach copy of certificate)

III. CONTACT INFORMATION

Billing Contact Name:	Phone:
Purchasing Contact Name:	Office Email:
FAX# FOR IMPORTANT REGULATORY INFORMATION	Fax:

BILLING ADDRESS (street, city, state, zip & COUNTY: for taxes)

SHIPPING ADDRESS (street, city, state, zip & COUNTY: for taxes)

IV. FINANCIAL INFORMATION

Bank Account (bank name, city):	Bank Phone:

Checking Account Number:

Request Prepay? ◯ Yes (if yes, provide details below) ◯ No		C.O.D.?: ◯ Yes ◯ No	
◯ American Express ◯ VISA ◯ Master Card	Card #: Card Holder Name:	Exp. Date:	Billing Zip Code:

V. CREDIT REFERENCES

Two CREDIT references (name, state, and phone):

(1)

(2)

The undersigned Facility/Doctor requests that an account with inx Medical be opened on behalf of Facility/Doctor. The Facility/Doctor authorizes the receipt and exchange information and agrees to be bound by all terms of the Account Holder Agreement and Disclosure Statement. The undersigned Facility/Doctor by its authorized officer all of the information provided above and in financial statement is true and correct; and that the inx Medical account requested will be utilized solely for business purposes. **I HEREBY ACKNOWLEDGE RECEIPT OF AND AG REE TO THE TERMS OF THE INX MEDICAL ACCOUNT HOLDER AGREEMENT AND DISCLOSURE STATEMENT, WHICH IS ATTACHED HERETO AND I NCORPORATED HEREIN BY REFERENCE, INCLUDING, BUT NOT LIMITED TO, THE DISCLAIMER OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.**

*** SEE ATTACHED INX MEDICAL ACCOUNT HOLDER AGREEMENT AND DISCLOSURE STATEMENT**

Signature of Financially Responsible Person DATE

Printed Name of Financially Responsible Person TITLE

Signature of Personal Guarantor (if required) DATE

INX MEDICAL ACCOUNT HOLDER AGREEMENT AND DISCLOSURE STATEMENT

All users of any inx Medical Account and Personal Guarantors of all inx Medical Accounts (hereinafter individually and collectively referred to as "you", "your", "we", and/or "our") agree to the following terms and conditions:

Agreement to Terms:
You agree to be bound by all terms of the INX Medical Account Holder Agreement and Disclosure Statement (hereinafter referred to as the "Agreement") and all amendments to this Agreement.

Promise to Pay:
You promise to pay all amounts incurred by (1) you, or from which you receive a benefit; or (2) others with actual, authorized, implied, or apparent authority to use your inx Medical Account (hereinafter referred to as "Account"). You agree to pay for charges incurred by others to whom you voluntarily provided your Account number.

Special Responsibilities for Accounts:
You agree to accept liability for any and all purchases made by your employees, whether or not the employee uses the Account in a manner authorized by you. Transfer of an Account from the doctor/facility named on the Account to another doctor/facility is prohibited; the Account must be closed and a new account must be opened for the new doctor/facility.

Payments:
Payments must be made within thirty (30) days of invoice date. Forms of payments accepted are check, money order, Visa, MasterCard, or American Express.

Collection Costs and Attorney Fees:
You agree to pay all collection costs, including reasonable attorneys' fees (including in-house counsel), incurred in collecting any amounts owed by you or in enforcing the provisions of this Agreement, whether or not suit is filed.

Security Interest:
In order to secure your obligations under your Account(s), your Account(s) may be secured by a lien on property and possessions.

Default:
If (a) you do not pay any invoice when it is due; or (b) you do not comply with any of the terms on the Account or this Agreement or any amendments to it; or (c) you do not pay any other debt when it is due; or (d) you change your primary place of business or (e) you die, become bankrupt or insolvent, or the entity holding your Account is dissolved or merged; or (f) you make any false, misleading or incomplete statements on your application, or (g) you fail to exercise due care in safekeeping your Account(s) or Account information which causes unauthorized use; inx Medical may, without waiving any available legal remedy, without notice or liability to you, do any or all of the following: (1) require you to pay the entire outstanding balance of your account immediately, (2) require additional purchases to be delivered COD (Cash On Delivery) plus the amount of the outstanding balance, (3) place your account on COD for a specified amount of time to be determined at our discretion, and or (4) suspend or terminate your account.

Change of Name and Address:
You agree to notify us in writing if you change your name or address. The notice must be sent to the address on your statement, Attn: Customer Care.

Shipping Terms:
FOB Destination

Sales Tax Terms:
All tax exemption certificates must be submitted to inx Medical prior to issuance of any invoice. If you do not submit the appropriate documentation prior to issuance of any invoice, inx Medical will charge the applicable sales tax. You are responsible for applicable sales tax, whether or not it is charged on the invoice.

Billing Disputes:
If you think your invoice(s), credit memo(s) or statement is incorrect, or if you need more information regarding an invoice or statement, contact inx Medical Customer Care at 1-888-469-8558. For disputes or questions regarding an invoice, you must contact Customer Care or an inx Medical Representative within thirty (30) days of the date of the invoice. After thirty (30) days, it is your responsibility to pay the invoice(s) in question.

Return Policy:
No credit can be issued for non-stock products or products that have been opened or damaged, including damage to the packaging of the product. You must request authorization before you return any items. To receive a return authorization number, contact Customer Service. Requests to return products must include the reason for return, the reference part number, the quantity, the lot number, and the invoice number. To receive any credit for returned products, all returned products must be received by inx Medical in their original, unopened packages and be undamaged and packed appropriately for shipping. To receive any credit for returned products, items must be in saleable condition and suitable for restocking. Returned items meeting all of the foregoing conditions (hereinafter referred to as the "Returned Item" or "Returned Items") will result in credit being applied to your Account as follows: (1) full credit will issue for Returned Items returned within thirty (30) days from the date of the invoice for the Returned Item; (2) Eighty-five percent (85%) credit will issue for Returned Items returned between thirty-one (31) and ninety (90) days from the date of the invoice for the Returned Item; (3) no credit will issue for any product returned after ninety (90) days from the date of the invoice for the product. Returned Items may be subject to a reprocessing charge. Freight charges and shipping & handling fees are non-refundable. Full credit will issue for any product that requires return due to a processing error by inx Medical. ALL CREDITS WILL BE ISSUED IN THE FORM OF CREDIT TO YOUR ACCOUNT.

Credit Balance Cash Refund:
All requests for refunds on credit balances must be made in writing to inx Medical, Attn: Customer Care, 1819 Clarkson Rd., Suite #206, Chesterfield, MO 63017. For specific criteria concerning cash refund eligibility, see our Cash Refund Policy under Returned Goods Policy located on the back of each statement, invoice, and credit memo.

Warranty Policy:
For product quality issues, please contact inx Medical Customer Service. In order to qualify under inx Medical's warranty policy, the product must be returned for evaluation within fifteen (15) days of RGA issuance. Standard product delivery includes a shelf life of one (1) year.

Choice of Law:
This Agreement shall be construed in accordance with the laws of the State of Missouri, as if this Agreement were made in and to be performed entirely in the State of Missouri. Any disputes under this Agreement shall be brought exclusively in the Circuit Court of St. Louis County, Missouri, and you hereby consent to the personal jurisdiction and exclusive venue of this court, and to service of process by mail, and waive any objection to such jurisdiction, venue and service of process.

***PERSONAL GUARANTOR – CORPORATE, LLC, LC or PLC ACCOUNT:**
The Personal Guarantor of the Account absolutely and irrevocably guarantees and promises to pay to inx Medical, in lawful money of the United States all amounts due on the Account when they become due (by demand, acceleration, or otherwise), all present and future indebtedness due to inx Medical on the Account, whether due or not due, absolute or contingent, liquidated or unliquidated, secured or unsecured, whether customer may be liable individually or jointly with others. Personal guarantor agrees not to assert any statute of limitations or unenforceability defenses with respect to any claims of inx Medical against Personal Guarantor pursuant to this Agreement. Without limiting the foregoing, indebtedness includes, without limitation, interest, attorneys' fees and other charges on any debt or obligation of any Account holder accruing after the filing of a petition under any chapter of the Federal Bankruptcy Code by or against customer, and any loans or other credit extended to any Account holder after the filing of any such petition, notwithstanding the release of customer from the performance or observance of any of its agreements, covenants or obligations by operation of law.

DISCLAIMER OF WARRANTIES:

UNLESS OTHERWISE EXPRESSLY PROVIDED HEREIN, INX MEDICAL WARRANTS TITLE TO THE GOODS AND THAT ALL GOODS SOLD HEREUNDER SHALL CONFORM TO SELLER'S STANDARD SPECIFICATIONS. SUBJECT TO THE PRECEDING SENTENCE, INX MEDICAL MAKES NO WARRANTY, EXPRESS OR IMPLIED, AS TO MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR ANY OTHER MATTER. INX MEDICAL EXPRESSLY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.