



Please provide contact information for the party completing this application:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Direct Phone Number: \_\_\_\_\_ Additional Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Company Name: \_\_\_\_\_ D.B.A.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Website: \_\_\_\_\_

DUNS Number: \_\_\_\_\_ Federal EIN Number: \_\_\_\_\_  
(Please include copy of Certificate)

Type or Category of Business: \_\_\_\_\_ Number of Years in Business: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Business a Corporation ☐ YES ☐ NO Business a Partnership ☐ YES ☐ NO

Please provide the contact information for (2) OFFICERS (if a corporation) or (2) PARTNERS (if a partnership)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Direct Phone Number: \_\_\_\_\_ Additional Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Direct Phone Number: \_\_\_\_\_ Additional Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

---

#### BANK AND CREDIT CARD INFORMATION

Disc Disease Solutions REQUIRES initial purchases are processed via CREDIT CARD / Disc Disease Solutions RESERVES THE RIGHT to charge overdue balances to credit cards

Primary Bank Name: \_\_\_\_\_ Bank Address: \_\_\_\_\_

Phone: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_ Checking Account Number: \_\_\_\_\_

CREDIT CARD INFORMATION - Please provide information for a CREDIT CARD, either personal or business.

Business Name On Credit Card: \_\_\_\_\_ Individual Name On Credit Card: \_\_\_\_\_

Type of Credit Card: ☐ VISA ☐ AMEX ☐ MasterCard Other: \_\_\_\_\_

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

---

#### BUSINESS/TRADE REFERENCES

Company Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Company Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Company Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Consent for Application and Credit Verification**

The undersigned hereby applies to Disc Disease Solutions for credit. It is understood and agreed upon that the undersigned specifically consents to Disc Disease Solutions investigating the applicant's credit history which may include the use of "Third Party" commercial and/or consumer credit reports for the purpose of extending credit.

**Pricing**

Prices are subject to change without notice. The most recent price list supersedes previously published price lists.

**Shipping Arrangements:**

All merchandise is shipped via FedEx unless otherwise specified. FedEx charges and a handling fee will be added to your bill. Shipments outside of the continental United States will be billed accordingly. FedEx requires an appropriate destination (NO P.O. BOXES) with an available signature provider, if needed.

**Billing Terms and Delinquent Account Policies:****Disc Disease Solutions, Inc. extends the following terms:**

1. Net balance due (30) days from the date of invoice.
2. Disc Disease Solutions RESERVES THE RIGHT to charge overdue balances and finance charges to credit card on file.
3. Orders will not be shipped on delinquent accounts.
4. Disc Disease Solutions reserves the right to terminate open account credit at any time.
5. If default of payment occurs, the customer agrees to pay any and all attorney's fees and collection costs, up to and including asset seizure.

\*This agreement continues as long as your invoices are paid within our terms of sale.

**Forms of Payment Include:**

1. Check (via U.S. Mail). There will be a \$25.00 service fee on all checks returned unpaid
2. Money order / Cashier check
3. Visa, M/C, AMEX, Discover

**Returns – Damaged, or Erroneously Shipped Merchandise – Requirements:**

1. Notifications of damaged, or erroneously shipped merchandise must be made within (14) days of receipt.
2. A "Return Merchandise Authorization" (RMA) number must be obtained first by contacting Disc Disease Solutions Customer Service at 888-495-7440.
3. The "Return Merchandise Authorization" (RMA) number must be written in bold ink on the outside of the box
4. Shipping charges for damaged or erroneously shipped merchandise will be paid for by Disc Disease Solutions.
5. Replacement of/or credit for the merchandise will be issued after a detailed inspection and determination of the claim.

**Returns – Defective Merchandise – Requirements:**

1. Please confirm that the merchandise that is believed to be defective is within the warranty time period.
2. A "Return Merchandise Authorization" (RMA) number must be obtained first by contacting Disc Disease Solutions Customer Service at 888-495-7440.
3. The "Return Merchandise Authorization" (RMA) number must be written in bold ink on the outside of the box
4. Shipping charges for defective merchandise will be paid for by Disc Disease Solutions.
5. Replacement of/or credit for the merchandise will be issued after a detailed inspection and determination of the claim.
6. A detailed description of the merchandise's defects as well as the proposed solution (REPLACEMENT or CREDIT) must accompany the merchandise.

**Return for Refund or Exchange – All Other Merchandise – Requirements:**

1. A "Return Merchandise Authorization" (RMA) number must be obtained first by contacting Disc Disease Solutions Customer Service at 888-495-7440.
2. Shipping charges for merchandise will be paid for by Customer.
3. All exchanges and non-defective / non-damaged returns must arrive and be found in first class condition to be considered for credit.
4. Replacement of/or credit for the merchandise will be issued after a detailed inspection and determination of the claim.
5. A detailed description of proposed solution (REPLACEMENT or CREDIT) must accompany the merchandise.

1) The undersigned hereby acknowledges and agrees that Disc Disease Solutions does not provide any indemnification, whether express or implied, including any indemnification imposed by statute to the undersigned. The undersigned hereby waives any right to indemnification from Disc Disease Solutions including any statutory indemnification. Further, the undersigned shall indemnify, defend and hold harmless Disc Disease Solutions and its directors, shareholders, officers, employees, subcontractors and agents from and against any and all liabilities, obligations, penalties, claims, judgments, demands, actions, disbursements of any kind and nature suits, losses, damages, costs and expenses (including, without limitation, reasonable attorney's fees) arising from the undersigned's actions or inactions, that relate in any way to this agreement or transactions between Disc Disease Solutions and will be held harmless the undersigned's business, including without limitation, any alleged products liability or negligence claims in connection with property damage or personal injury (including without limitation death) of third parties, or any claim that the manufacture, use, sale, or offer for sale of any intellectual property rights infringes upon the intellectual property rights of any third party.

2) The undersigned will protect Disc Disease Solutions Confidential Information from unauthorized dissemination and use with the same degree of care that the undersigned uses to protect its own like information, but at a minimum, with a reasonable degree of care. The undersigned will not use Disc Disease Solutions Confidential Information for purposes other than those necessary to perform this Agreement and only employees of the undersigned who have a need to know such Confidential Information will have access thereto. The undersigned will not disclose to third parties Disc Disease Solutions Confidential Information, in regards to any and all details of business, without the prior written consent of Disc Disease Solutions.

3) This Agreement shall be construed and fairly interpreted in accordance with its terms, without any strict construction in favor of/or against either party. Ambiguities shall not be interpreted against the drafting party. In construing or interpreting this Agreement, the word "or" shall not be construed as exclusive, and the word "including" shall not be limiting. The use of the singular or plural form shall include the other form and the use of the masculine, feminine or neuter gender shall include the other genders.

4) If any provision of this Agreement is held to be ineffective, unenforceable or illegal for any reason, such decision shall not affect the validity or enforcement of any or all of the remaining portions thereof.

5) The undersigned agrees that any dispute with Disc Disease Solutions whatsoever shall take place solely in the forum of New Jersey, and that New Jersey law applies to all disputes. Should a dispute arise between the parties, and if Disc Disease Solutions is the prevailing party, the undersigned agrees that Disc Disease Solutions is entitled to a reasonable award of its attorney's fees incurred in prosecuting or defending the action. The undersigned agrees that this fee shifting provision inures to the benefit of Disc Disease Solutions only.

I have read, understand, and agree to the above Account Agreement and Terms of Sale policies. I understand that the Account Agreement and Terms of Sale policies may change at any time, and that I will be notified of such changes by US mail.

**Signature Requirements:**

**Corporation: (2) CORPORATE OFFICERS' signatures required. Partnership: (2) PARTNERS' signatures required.**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_