

# ORDER FORM

## NEW NEIGHBOR™ PROGRAM

Practice Name .....

Street .....

City ..... State ..... Zip .....

Office Phone Number ( ) ..... Email .....

### PROGRAM FEE

There is a program fee of \$350 that is payable upon receipt of this Order Form. This includes all zip code areas you may select.

### MONTHLY PRICING

Select the Quantity and Pricing that best fits your location:

500 Homeowners  
\$195 per month

750 Homeowners  
\$250 per month

1000 Homeowners  
\$335 per month

Note: Package Prices are payable for 12 consecutive months.

Indicate the zip code(s) you desire to reserve:

### CREDIT CARD

*I hereby authorize The Transform Group (parent company of Xpand Medical) to automatically charge my credit card for twelve consecutive months for the services ordered above. The \$350 program fee will be charged immediately.*

Name on Credit Card .....

Credit Card Billing Address .....

Credit Card ..... American Express ..... VISA ..... MasterCard ..... Discover

Credit Card # ..... Expiration Date ..... Security Code .....

Authorized Signature ..... Date .....

Please Fax this order to **770.729.9191** Thank you for your business!



Mike Tiller, Manager of Client Services  
mtiller@thetransformgroup.com  
Atlanta: 678.942.8409  
National: 866.942.8440  
Website: www.xpandmedical.com