

For Lab Use Only

Order Date: Due Date:

Dr. Name: License #:

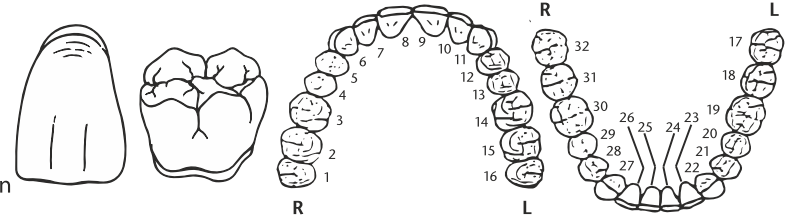
Practice Name:

Patient Name (Please Print):

Shade

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Posterior Occl. Stain



Please print detailed instructions to avoid processing errors:

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We Need: Bags  Rx Pads  Mailing Labels 

Doctor Signature:

I agree full remittance of charges incurred by this prescription is payable within fifteen days of receipt of statement and further agree to pay all costs incurred in collection should I default, including without limitation, reasonable attorneys fees and a monthly service charge of two percent of outstanding balance.

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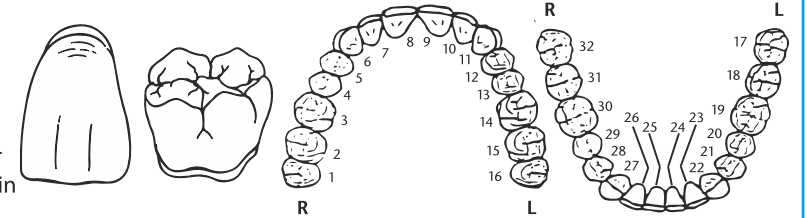
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