

SaeboStim Pro | Patient Order Form

Questions? Call 888.284.5433 | Fax this order form to 855.414.0037



▶ 1. PATIENT

Order Date:	The FDA requires a prescription from your doctor before use. Please consult with your physician and obtain a prescription stating “Electrical Stimulation for muscular disuse atrophy”. <u>The prescription must be provided to Saebo prior to shipment.</u>		
First Name:			
Last Name:			
DOB:	Telephone:	Email:	

SHIP TO: SAEBO, INC. CANNOT SHIP DEVICES TO P.O. BOXES. IF THE DEVICE IS BEING SHIPPED TO A FACILITY, BE SURE TO INDICATE THE FACILITY NAME.

Recipient or Facility Name:	Attention:		
Street:	Dept./Suite:		
City:	State:	Zip:	
Telephone:			

▶ 2. THERAPIST (Optional)

Current (or Last) Therapist:	Facility Name:
Email:	

▶ 3. DEVICE

IF ORDERING THE ACCESSORY KIT, PLEASE USE THE INSTRUCTIONS ON THE THIRD PAGE TO DETERMINE THE CORRECT SIZE. CIRCLE THE CORRESPONDING SIZE AND INDICATE THE QUANTITY IN THE SPACES BELOW. MEASURE CAREFULLY & ACCURATELY!

	DESCRIPTION							PRICE	QTY	TOTAL
	Shipping within the US? Add \$4.99 for Shipping Shipping to Canada? Add \$35⁰⁰ for Shipping	<i>SaeboStim Pro, Complete Unit</i>							199.00	
<i>SaeboStim Pro, Sensory Electrical Stimulation (SES) Accessory Kit</i>		Arm Size	S	M	L	XL		99.00		
		Hand Size	XS	S	M	L	XL			
<i>SaeboTrodes Replacement Electrodes, Round 1.25 inch / 3.2cm (4/pack)</i>		1 pack						7.20		
		10 pack						57.60		
<i>SaeboTrodes Replacement Electrodes, Round 2 inch / 5cm (4/pack)</i>		1 pack						8.10		
		10 pack						64.80		
<i>SaeboTrodes Replacement Electrodes, Rectangle 2 x 3.5 inch (4/pack)</i>		1 pack						9.90		
		10 pack						79.20		
SUB-TOTAL										
SHIPPING										
TOTAL PURCHASE										



▶ 4. PAYMENT

Pay by Credit Card | Card Type: MC Visa Amex Discover

Card Number: _____ Exp: _____ Name on Card: _____

CVC: _____ Billing Address: _____

I hereby authorize the charge of the Total Purchase shown on Page 1 of this order form.
(Total Purchase includes \$4.99 domestic shipping or \$35.00 to ship to Canada)

Signature of Card Holder: _____

Mail a Payment (US Delivery Only) | **If paying by Check or Money Order, mail this form and your payment + shipping to:**

Saebo, Inc.
2459 Wilkinson Blvd, Suite 120
Charlotte, NC 28208

▶ 5. PROTECTED HEALTH INFORMATION

Read the following information and sign below.

Permission to be Contacted About Products: I hereby grant Saebo, Inc. (and its affiliates) permission to contact me by telephone (or by mail, email, fax, instant messaging, or other electronic communication) in order to provide information about current or future products or services which may be useful in my medical treatment. **Consent to Use and Disclose Protected Health Information:** Saebo, Inc.'s Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting the Privacy Compliance Officer at the following address: SAEBO, INC., 2459 Wilkinson Blvd, Suite 120 Charlotte, NC 28208. You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment or health care operations. Saebo, Inc. is not required to agree to this restriction, but if we do, we are bound by our agreement.

I hereby acknowledge that I have been made aware of, and fully understand my rights and responsibilities as a patient. I hereby authorize the release to Saebo, Inc., and release by Saebo, Inc. any necessary medical records, test results, etc., from any previous physicians, hospitals, etc., which will assist with the provision of any product or service which may be deemed appropriate for my medical treatment including the release of information to any healthcare provider, insurer, third party billing agency, or third party medical supplier. **Assignment to Assign Benefits and Pay All Charges Not Covered by Insurance:** I hereby assign all medical insurance benefits to which I am entitled to Saebo, Inc. for any items or services furnished to me by that provider. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Saebo, Inc. for any services rendered. I understand that I am responsible for any amount not covered by insurance. I understand that once an item had been custom fabricated for my use, my financial responsibilities will continue regardless of whether I choose to accept delivery of that item.

Patient Signature: _____ Date: _____

SaeboStim Pro Accessory Kit | Clinical & Measurement Guidelines

1. Clinical Appropriateness

<p>Indications for Use:</p> <p>TENS:</p> <ol style="list-style-type: none">1. Symptomatic relief and management of chronic intractable pain.2. Adjunctive treatment for post-surgical and post-trauma acute pain. <p>NMES:</p> <ol style="list-style-type: none">1. Relaxation of muscle spasm.2. Prevention or retardation of disuse atrophy.3. Increasing of local blood circulation.4. Muscle re-education.5. Immediate post-surgical stimulation of calf muscles to prevent venous thrombosis.6. Maintaining or increasing range of motion. <p>Important: Electrical stimulation devices should only be used under medical supervision for adjunctive therapy for the treatment of medical diseases and conditions.</p>	<p>Contraindications:</p> <p>TENS</p> <ol style="list-style-type: none">1. Do not stimulate over the carotid sinus nerves, laryngeal or pharyngeal muscles (anterior throat area); severe spasm may occur causing contractions that may be strong enough to close the airway or cause difficulty in breathing.2. Do not use TENS device on undiagnosed pain symptoms until the etiology has been established.3. Do not place electrical current transcranially (through the head).4. Do not use TENS on patients wearing a demand type cardiac pacemaker. <p>NMES</p> <ol style="list-style-type: none">1. Electrical stimulation devices are contraindicated for patients with cardiac demand pacemakers. <p>Electric stimulation devices should not be used on cancer patients.</p>
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2. How to Measure

To maximize comfort and fit, there are (2) measurements required. The two measurements will indicate the best possible size recommendation. Use a measuring tape to take your measurements. If you do not have measuring tape, use string and then measure the string with a ruler. Circle your size on Page 1 of this form in the space provided.



Find Your Arm Size: Measure arm circumference by wrapping tape circumferentially around the middle portion of the biceps muscle.

ARM SIZE
Small: 6" - 10"
Medium: 10" - 14"
Large: 14" - 18"
X-Large: 18" - 23"



Find Your Hand Size: Measure hand circumference by wrapping tape circumferentially around the hand.

HAND SIZE
X-Small: 6" or <
Small: 6" - 6.5"
Medium: 6.5" - 8"
Large: 8" - 9"
X-Large: 9" or >