
# New Account Setup Packet

# True Woundcare Company Information

**Company Remit to Address:**

True Woundcare
P.O. Box 780241
San Antonio, TX 78278

**How to order:**

First time order: Please complete all forms (setup and order form) and email to orders@truewoundcare.com

Existing accounts: Please completely fill out order form and email to orders@truewoundcare.com

**Net Terms: 30 Days(*)**

*Special Order or high-volume orders are subject to a 30% non-refundable deposit with balance due 30 days from date of final invoice.

**Customer Service:**

Phone:  888.880.TRUE
Email:  info@truewoundcare.com

Thank you for your business!

P.O. Box 780241
San Antonio, TX 78278
Phone: 888.880.TRUE
www.truewoundcare.com

# NEW ACCOUNT SET UP SHEET

## BILL TO INFORMATION:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County (this facility is located within): _____

## SHIP TO INFORMATION: (If Same, please indicate by writing "SAME")

Address: _____

City: _____ State: _____ Zip: _____

## CONTACT INFORMATION:

Main Telephone Number: _____ Main Fax Number: _____

Order Desk Contact: _____

Phone: _____ Fax: _____ Email: _____

Accounts Payable Contact: _____

Phone: _____ Fax: _____ Email: _____

## TAX EXEMPT STATUS:

Is your Facility Tax Exempt? _____ YES _____ NO

If Yes, please attach a copy of tax-exempt certificate to the application. Orders cannot be placed without tax-exempt certificate on file.

## SIGNATURE:

Completed by: _____ Date: _____

Title: _____

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# Order Form

## True3 Digital Mattress Systems with Tri-Phasic Technology

To place order: Please email this completed form to **orders@truewoundcare.com** ( Required Info * )

* Order Date: _____ * PO #: _____ * Contact Phone: _____

* Name of Customer: _____ * Contact Name: _____

* Shipping Address: _____

* City, State, & Zip: _____ * Contact Email: _____

| Order | Item Number | Product Description | Qty |
|---|---|---|---|
| | | STANDARD 36(in) FULL MATTRESS SYSTEMS | |
| _____ | TTMS-3000 | True3 Digital Mattress System-Standard | 1 ea. |
| _____ | COVTTD-S | True3 Digital Replacement Mattress Cover-Standard | 1 ea. |
| _____ | PUMPTTD-S | True3 Digital Replacement Pump-Standard | 1 ea. |
| _____ | MATTTTD-S | True3 Digital Replacement Mattress- Standard | 1 ea. |
| | | BARIATRIC 42(in) FULL MATTRESS SYSTEMS | |
| _____ | TTDE-3030 | True3 Digital EXTRA Mattress System-Bariatric | 1 ea. |
| _____ | COVTTD-B | True3 Digital Replacement Mattress Cover- Bariatric | 1 ea. |
| _____ | PUMPTTD-B | True3 Digital Replacement Pump- Bariatric | 1 ea. |
| _____ | MATTTTD-B | True3 Digital Replacement Mattress- Bariatric | 1 ea. |
| _____ | EXTWTTD | True3 Digital System Extended Warranty (addt'l 12 mo.) | 1 ea. |

## Shipping Preferences (Please select your shipping preference below)

| | | |
|---|---|---|
| _____ | Standard Ground Shipping | (3 to 5 business days) |
| _____ | Express Shipping 2nd day | (2 business days) |
| _____ | Express Shipping Overnight | (Next day morning delivery) |
| _____ | Express Shipping Overnight | (Next day afternoon delivery) |
| _____ | Express Shipping Overnight | (Next day morning/Saturday delivery) |

If a shipping preference is not selected prior to emailing or calling order, your order will automatically ship Standard Ground.
All standard and expedited shipping preferences will be charged to the customer.

**Thank you for choosing True Woundcare, we appreciate your business!**

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us in writing at info@truewoundcare.com. This authorization will remain in effect until notified otherwise by email.

## Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): _____

Billing Address Associated with this Credit Card: _____

City: _____ State: _____ Zip Code: _____

Card Number: _____

Expiration Date (mm/yy): _____

CVV Number (Visa, Mastercard, Discover- 3 Digit Numeric Number): _____
**Number found on back of Credit Card**

CVV Number (American Express- 4 Digit Numeric Number): _____
**Number found on front of Credit Card**

By signing this authorization, I,_____, authorize True Woundcare to charge my above credit card. I understand that my information will be saved & protected to file for future transactions on my account that exceed the 30-day net terms as well as any monthly reoccurring supply orders you wish to have billed to this card.

_____ _____

Customer Signature Date