

An Invoice is Included with Your Order.

- Call the Billing Department at 1-800-279-5708, press option 4, to phone in your credit card (VISA/MasterCard/Discover/American Express) payment.

Please note: you may call and request to keep your credit card on file for our Auto Pay Plan to automatically charge future orders when ordered by you or your practitioner. Call for more details.

INVOICE

Women's International Pharmacy
PO Box 6468
Madison, WI 53716

Telephone: (800) 279-5708
(Press Option 4 For Billing Questions)

Invoice: 166394
Page: 1
Date: 01/14/2010
Time: 1:52:37 PM
ADM WOMEN'S INTERNATIONAL PHARMACY-WI



SHIP TO

Name: Thunders, John
Address: 101 Home St.
Charleston, SC 29401
Phone:
Email:

Your account number is: 48563

Rx# Order #	Refills Remaining	Disp Date	Date Written	Item Name	Disp Qty	Days Supply	Price	Customer Pay
W032104	3.00	01/14/2010	01/14/2010	P-PROGESTERONE 100	10	30	\$48.00	\$48.00
T012942	3.00	01/14/2010	01/14/2010	L-TESTOSTERONE 0.5	15	30	\$12.75	\$12.75
W010417	4.00	01/14/2010	10/11/2009	C-E1 0.01/E2 0.08/E3 0.28	10	1	\$10.00	\$10.00

Amount This Order: \$70.75
Shipping: \$6.00
Total Due This Order: **\$76.75**
Paid by credit card.

Shipping Method: FedEx Standard Overnight® Package

Priority: Next Day - PM

Shipping Comments: per pt request, send Fed Exp overnight

Credit Card Payment Information

Visa xxxxxxxxxxxxxx9999

Amount: **\$76.75**

Auth#: **024-1234567891**

Payment is required at the time of the order. Price subject to change without notice.



Refill Order Form

Please fill out information below and return with payment to:
Women's International Pharmacy • P.O. Box 6468 • Madison, WI

To Pay with MasterCard/VISA/Discover/AMEX

Card Number: _____ **Please initial here to keep your card on file:** _____
Expiration Date: _____ Daytime Phone Number: () _____ - _____

Name: John Thunders

Phone: _____

Prescription(s): _____

Please SHIP my prescription(s) on: _____ (Day) of _____ (Month).

Your account number is: **48563**

Verify or Add Email: _____

ABOUT YOUR INVOICE

1 - Please reference your account number for all payments and correspondence.

2- MEDICATION FORMS

C or CB = Cream
CS, CG or NS = Misc. Topical
D, DB or DS = Drops
G or GB = Gel
I = Injectable
L or LB = Lozenge
N or NB = Non-Alcohol Gel
O = Non-Prescription
P, PB or PS = Capsule
R = Insert
S = Suspension
TM = Trace Mineral
V, VB or VS = Suppository

3 - INGREDIENT ABBREVIATIONS

E1 = Estrone TE = Testosterone
E2 = Estradiol T3 = Liothyronine
E3 = Estriol T4 = Levothyroxine
P = Progesterone
D = DHEA F = Folic Acid
H = Hydrocortisone CQ = Coenzyme Q-10
PR = Pregnenolone M = Melatonin
TE = Testosterone
T3 = Liothyronine
T4 = Levothyroxine

4 - The total amount of order including shipping.

5 - The shipping method is US Priority Mail® unless expedited service is requested.

6 - The shipping comments pertaining to order.

7 - Credit card payment information may be reflected.

8 - To order future refills, please return form with payment.

9 - Can provide initials for authorizing your Credit card to be kept on file for future orders.

10 - Verify or add email address.