

Qty	Product	Price	Total
	Clinical Practice Guidelines: Examination And Intervention For Rehabilitation (3rd Edition)*	\$179.00	
	Therapy Referral Handbook (3rd Edition)*	\$35.00	
	Customize Handbook cover with your clinic logo— <i>minimum order of 40 books required (one-time setup fee)</i>	\$100.00	
	CareConnections Outcomes System <i>See below for quantity discount rates</i>	\$500.00	
	Add Patient Satisfaction Option to Outcomes	\$125.00	
	Back Basics DVD*	\$795.00	

Sales Tax (Multiply this line by 0.0725 for CA shipping addresses) Product Subtotal _____

(See chart below) Shipping & handling _____

Sales Tax (Multiply this line by 0.065 for WA or by 0.06 for ID shipping addresses) Subtotal _____

Sales Tax _____

Total _____

Shipping and Handling (* for applicable products)

All orders will ship via UPS Ground to the continental US.

Alaska and Hawaii customers, please call for shipping and handling rates.

No of Items	S&H fee	No of Items	S&H fee
1	\$10.95	4	\$16.95
2	\$12.95	5	\$18.95
3	\$14.95	6 +	Add \$1.50 for each additional item over 5

Outcome and Patient Satisfaction Fees

Quantity	Discount	Annual Fees per Site	
		Outcomes	Patient Satisfaction
1	0%	\$500.00	+\$125.00
2–25	20%	\$400.00	\$100.00
26–75	25%	\$375.00	\$93.75
76–175	30%	\$350.00	\$87.50
176–375	35%	\$325.00	\$81.25
376–750	40%	\$300.00	\$75.00
750+	45%	\$275.00	\$68.75

Guideline and Handbook Discount Rates

Quantity	Discount	Guideline Unit Price	Handbook Unit Price
1	0%	\$179.00	\$35.00
2–9	5%	\$170.05	\$33.25
10–49	15%	\$152.15	\$29.75
40–75	25%	\$134.25	\$26.25
75+	30%	\$125.30	\$24.50

ORDERS, INFORMATION, AND SUPPORT

By Phone

Phone in your order at (800) 219-8835

By Mail

Mail this form to:
 CareConnections
 ATTN: Order Processing
 11481 SW Hall Blvd., Suite 201
 Portland, OR 97223

By Fax

Complete this form and fax it to
 (503) 639-9699

By E-mail

Complete this form and e-mail it to
 support@careconnections.com

Customer Service Hours
 8 am–5 pm Pacific Time

www.careconnections.com

INFORMATION

Customer Name _____

Company _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Contact Phone _____

E-mail Address _____

Please supply physical address for delivery. **We will not ship to a PO Box.**

Therapeutic Associates, Inc. respects your privacy. We will not distribute your personal information to anyone.

PAYMENT

Please bill my credit card: MasterCard Visa Discover

Card No _____

Expiration Date (month/year) _____

Signature _____

Check enclosed, made payable to: Therapeutic Associates, Inc.