PAYMENT FORM

Patient' s Name: ____

Email Address: ____

Quantity	Drescription	Price	Amount
	* 3 Month Supply of Diennet	$630.00	
	* Rush	$ 50.00	
Note: * Orders are shipped in 3 month increments.			
		TOTAL	$

-Charge my : Visa Master Card American Express Discover

Account Number: ______________________________

Expiration Date: ______________________________

Billing Information for the above credit card:

First Name:

Last Name:

Street address:

City:

State:

Zip Code:

Country:

Work Phone:

Home Phone:

______________________________ ________________

Cardholder's Signature **Date**

The Diennet Institute
9454 WILSHIRE BLVD, M4
BEVERLY HILLS, CA 90212
Phone# 1-800-272-3436 or 1-310-277-3436