



# GDx RENTAL FORM

DOCTOR: \_\_\_\_\_ DATE: \_\_\_\_\_

OFFICE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

## PATIENTS SCANNED

1.	16.
2.	17.
3.	18.
4.	19.
5.	20.
6.	21.
7.	22.
8.	23.
9.	24.
10.	25.
11.	26.
12.	27.
13.	28.
14.	29.
15.	30.

## GDx RENTAL FEE CALCULATION

Option 1:  
(Same Day Payment ) Patients Scanned \_\_\_\_\_ X \$40/Patient X 6.25% State Tax = \$ \_\_\_\_\_ Total

Option 2:  
( 30 Day Billing) Patients Scanned \_\_\_\_\_ X \$45/Patient X 6.25% State Tax = \$ \_\_\_\_\_ Total

SEND PAYMENTS TO: MOBILE GLAUCOMA DIAGNOSTICS  
21 ROSS LANE  
MARSTONS MILLS, MA 02648

TEL (774)222-3235

Auth Sig: \_\_\_\_\_