

<b>DATE EFFECTIVE: 08/17/10</b>	<b>Billing Agreement</b>	<b>FORM: DIS.10ag REV: K</b>
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**Cryogenic Laboratories, Inc.**

3015 Williams Drive, Ste 110, Fairfax, VA 22031

Phone: 800.466.2796 Fax: 651-489-8989 Email: [info@cryolab.com](mailto:info@cryolab.com) <http://www.cryolab.com>

I understand a payment of \$290 is required to be sent with each mail-in specimen or \$230 for each specimen collected onsite, for laboratory processing charges, in addition to the storage fee selected below.

**Addendum to Storage Agreement**

This addendum is included in and made part of the *Storage Agreement*. A signed Billing Agreement must be returned to Cryogenic Laboratories, Inc. with a signed Storage Agreement. If you have completed a Storage Agreement in the past and this is a billing account renewal, a new Storage Agreement is not needed. **QUARANTINE FEES APPLY TO STORAGE WHERE REQUIRED TESTING IS INCOMPLETE OR CLIENT HAS A REACTIVE TEST RESULT.** Please select only one option.

**Option 1 Automatic MONTHLY charge of \$ 40.00 per month to the credit card listed below (\$80.00 per month for Specimens in Quarantine)**

I authorize Cryogenic Laboratories, Inc. to charge our credit card \$40.00 or quarantine fee for any specimens in storage on the 5<sup>th</sup> of each month. I understand that these storage fees **will be charged during the second week of every month** until we notify Cryogenic Laboratories, Inc. in writing that we no longer wish to continue this billing method. Any cancellation or changes to the Billing Agreement requires written notification to Cryogenic Laboratories, Inc.

I understand that choosing one of the following Pre-paid options requires full payment at the beginning of the selected term. I have enclosed a check or hereby authorize you to charge the credit card listed below for the storage fees for the selected term plus any due or past due storage charges. *Cancellation of an annual or multi year storage contract for any reason before the completion of the term will result in a \$50.00 administration fee* being subtracted from any refund of storage fees pro-rated over the storage period used based on the current monthly storage fee in effect. Any cancellation or changes to the Billing Agreement requires written notification to Cryogenic Laboratories, Inc., including extending or renewing the storage period. All storage fees must be paid in full before extending or renewing the storage period.

- Option 2 Pre-paid 1 year \$ 320.00 (~35% savings) \$640.00 for Specimens in Quarantine**
- Option 3 Pre-paid 3 year \$ 710.00 (~50% savings) \$1420.00 for Specimens in Quarantine**
- Option 4 Pre-paid 5 year \$ 1120.00 (~55% savings) \$2240.00 for Specimens in Quarantine**

If you desire to transfer, use, donate, or discard your stored specimens at any time, simply notify Cryogenic Laboratories, Inc. and Cryogenic Laboratories, Inc. will provide you with the appropriate document(s) to complete and return to us. **Please note, FAX COPIES ARE NOT ACCEPTED for transfers or discards.** Automatic charges to your credit card will be discontinued upon receipt of the **ORIGINAL SIGNED** authorization form informing us of your dispositional instructions. If you have any questions concerning your account please call 800/489-2294. Thank you for trusting Cryogenic Laboratories, Inc.

If at any time storage charges are due and owing but remain unpaid, Cryobank will pursue collection of the storage charges, including referral of claim to a collection agency. In that event, Client agrees to pay all costs of such collection including any reasonable fees charged by the collection agency, other costs of collection, and reasonable attorney's fees. See your storage agreement in regards to the termination of your account and the abandonment of the stored specimens. It is imperative that you notify Cryogenic Laboratories, Inc. of any change in address and extended absences or sabbaticals.

Storage client (print name) \_\_\_\_\_ Account# \_\_\_\_\_

Storage client signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment Method:**

**Credit card** (enter card information below)  **Personal check** (accepted for pre-paid option only)

Card type  VISA  MasterCard  Discover  American Express

Card Number \_\_\_\_\_

Name as it appears on credit card \_\_\_\_\_ Expiration date (mm/yy) \_\_\_\_\_

Cardholder's signature \_\_\_\_\_ Date \_\_\_\_\_

<input type="checkbox"/> Staff use only
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