



PRESCRIPTION

Patient: _____

DOB: _____

Advanced Therapy Concepts' Program with:

- Optimax S4000 (IFC, NMES)
- Micro-Z (HVPG stimulator with garment electrode)
- Perfect Stim NMES Stimulator
- X-Cel 4000 Stimulator (IFC, NMES)

Dispense as Written

*** No substitution of product or program***

Duration: **3 – 12 months rental**
or **purchase** if necessary

Supplies as needed

Garment Electrode System

Reusable Disposable Electrodes

Lead Wire(s)

Rechargeable Batteries

Conductive Mist

Disposable Batteries

A/C Wall Adapter

Battery Charger

Diagnosis: _____

Comments: _____

By: _____

Physician's Signature (**Required**)

Date: _____

Physician's Name, Address and Phone:

NPI # _____

Phone # _____

Fax # _____



Advanced Therapy Concepts
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