



[www.wellstarhealthplace.org](http://www.wellstarhealthplace.org)  
**ORDERS DUE NOON WED**

**Order Form- Pick up at Health Place Only**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

**Member Number or Department:** \_\_\_\_\_

**EMAIL** \_\_\_\_\_

**Please check your choice below**

**5 day plan: \$ 105.00 + Tax for 1200 calorie** \_\_\_\_\_

**\$ 125.00 + Tax for 2000 calorie** \_\_\_\_\_

**7 day plan: \$125.00 + Tax for 1200 calorie** \_\_\_\_\_

**\$150.00 + Tax for 2000 calorie** \_\_\_\_\_

**Please indicate method of payment:**

**Cash: (Only if paid in person at Health Place)**

**Check:** \_\_\_\_\_

**Credit card (number):** \_\_\_\_\_ **Exp.** \_\_\_\_\_

**Payroll Deduction (employee ID):** \_\_\_\_\_

**Payment Details:**

- All orders must be prepaid in full at time of order. Payroll deducts can not be split.
- All orders are non refundable.

*I agree to all above terms and payment. Signature and Date required*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fax back form to 770-793-7922 Health Place**  
**Information please call 770-793-7300**