Physician/Clinic Information Form

REQUIRED: Please provide the following information:

(1) A copy of medical license for each prescribing physician or practitioner (MD, DO, ARNP, NP or PA).

- **(a) This includes a copy for every state that each prescribing physician or practitioner are licensed in.**
- **(b) This includes a copy for every state controlled substance license that each prescribing physician or practitioner holds in the following states:** AL, CT, DE, DC, HI, ID, IL, IN, IA, LA, MD, MA, MI, MO, NV, NJ, NM, OK, RI, SC, SD, UT, WY

(2) A copy of the DEA license for each prescribing physician or practitioner (MD, DO, ARNP, NP or PA).

(3) NPI number for each prescribing physician or practitioner (MD, DO, ARNP, NP or PA).

(4) Center City Pharmacy, or affiliated pharmacies, requires each physician or practitioner (MD, DO, ARNP, NP or PA) to review and sign the Protocol Form, outlining the process for patient care and patient-physician-relationship.

(5) A credit card is required prior to ordering, the card will be charged the same night of shipping.

Disclaimer:

(1) An additional $5.00 will be charged when choosing the signature required. This provides insurance for the package. FedEx will not leave package without a signature, therefore someone will need to be home. If the signature option is not chosen, there is no insurance coverage for the package.
(2) All information provided on and with this document is authorized to be used with Center City Pharmacy or affiliated pharmacies.
(3) Once submitted, all electronic and written signatures are valid and used as authorization from the given clinic to use and process all information provided.

Representative: House **Affiliated Group:** _____ **Date:** _____

Associated Physicians or practitioners (ARNP or PA): All fields are required.

Medical Director/Head_____DEA _____Med License_____NPI_____

Prescriber 2_____DEA _____Med License_____NPI_____

Prescriber 3_____DEA _____Med License_____NPI_____

Phone:_____Fax:_____Website:_____

Primary Practice Contacts:

Name/Title: _____ Name/Title _____

Email: _____ Email: _____

Clinic/Practice Information:

Clinic/Practice Name:_____

Hours of Operation:_____ Type of practice:_____

Address:_____

City:_____St:_____Zip:_____

Billing Instructions:

Invoice: (check box)

☐ Bill Physician/Clinic Credit Card

For Office Use:

Sales Person: ____House ___

Name on Credit Card: _____

***Credit Card Number: _____Exp:_____ Security Code:_____

E-mail invoices to: _____

Billing address:

Address: _____

City: _____ St:_____Zip:_____

☐ Initial

To ensure that our accounting staff has sufficient time to address the concerns and needs of all of our customers, please submit any adjustments/refund requests from billing discrepancies in writing within 15 days of receipt of the invoice. Center City Pharmacy or affiliated pharmacies will not honor refund requests submitted after 15 days.

I authorize Center City Pharmacy or affiliated pharmacies to charge the credit card given above.

Credit Card Owner's Signature: _____

It is understood that Center City Pharmacy or affiliated pharmacies utilizes FEDERAL EXPRESS as a traditional method of shipping. It is further understood that Center City Pharmacy or affiliated pharmacies will choose the specific shipping vendor unless a specific shipping preference is noted on the prescription. Please include shipping instructions on the prescriptions or ground with no signature required will be selected as a default. Shipping options include, Overnight, Overnight AM, 2nd Day, Ground with or without signature required. Note that all cold products will default to shipping Overnight with AM delivery.

It is also understood that by choosing no signature required the physician and or patient is accepting full responsibility for the delivery of the package. In the event no signature required is chosen or defaulted, and the delivery vendor tracking indicates delivery, the patient and/or clinic will be held responsible for payment of the prescription. It is also understood that if no signature required is chosen, or defaulted, for a schedule drug the patient and/or clinic be responsible for payment of the prescription and that schedule drugs will not be replaced (regardless of additional payment). Schedule drugs can only be shipped to the patient's address. If a schedule drug is deemed stolen, it must be reported to the local police department.

Center City Pharmacy or affiliated pharmacies must be notified within 48 hours of receipt of goods if products are missing from the shipment. Shortages not identified within the 48-hour-window will not be subject to replacement or reimbursement. A new prescription must be issued by the prescriber and additional payment will be required. To ensure that our accounting staff has sufficient time to address the concerns and needs of all of our customers, please submit any adjustments/refund requests from billing discrepancies in writing within 15 days of receipt of the invoice. Center City Pharmacy or affiliated pharmacies will not honor refund requests submitted after 15 days.

Physician Protocol Form:

Please indicate Type of Practice:

Patient-Physician-Relationship:

Center City Pharmacy and affiliated pharmacies are committed to continuous compliance with state and federal laws. Some patients may reside in states outside the prescribing physician's state. To ensure that all prescriptions received by Center City Pharmacy are pursuant to a valid patient-physician-relationship, Center City Pharmacy and affiliated pharmacies require that the prescribing physician agree that the following standards are met before sending in a prescription:

1. A documented patient evaluation, which includes history and physical exam, to establish diagnosis for any prescribed drug.
2. Adequate and sufficient dialogue between the prescribing physician and patient about the options, benefits, and risks associated with the treatment.
3. Current and complete medical records are maintained by the physician.

By signing this form you agree that all prescriptions sent to Center City Pharmacy or affiliated pharmacies have met the standards above and are in full compliance with state and federal laws regarding a valid patient-physician-relationship.

Commonly Prescribed Medications:

Individual signing below has reviewed this Physician/Clinic Information Form in its entirety and understands the provisions set forth in this form. If the signature is auto filled, you are acknowledging the same terms and conditions set forth in this form.

Clinic Owner Signature: _____ Date: _____

Upon completion, form must be emailed as a pdf to newaccounts@centercityrx503a.com or registration@onestopcompounds.com