VERTISIS®
CUSTOM PHARMACY

9343 E. Bahia Dr. Suite 200
Scottsdale, AZ 85260
Phone: 1-888-285-5841
Fax: 480-625-4276
www.Vertisis.com

New Clinic Form

And Credit Card Authorization Form

Prescribing Facility Name:

Shipping Address: **Contact Person:**

Phone Number:

Fax Number: **Contact Email:**

Prescribing Physician: ○ N.M.D. ○ D.O. ○ M.D. ○ P.A. ○ N.P.

NPI #: **DEA #:**

Prescribing Physician: ○ N.M.D. ○ D.O. ○ M.D. ○ P.A. ○ N.P.

NPI #: **DEA #:**

Prescribing Physician: ○ N.M.D. ○ D.O. ○ M.D. ○ P.A. ○ N.P.

NPI #: **DEA #:**

Please Fax to (480) 625-4276 or Email to accounts@vertisis.com

Sign and complete this form to authorize Vertisis Custom Pharmacy LLC. to debit your credit card listed below for compounded medications. By signing this form, you give permission to debit your account for the invoice amount indicated on or after the indicated date. This is permission for on-going transactions requested by provider or provider's office, and does not provide authorization for any additional unrelated debits or credits to your account.

Credit Card Type: ○ AMERICAN EXPRESS ○ VISA ○ MasterCard ○ DISCOVER

Card Number: **Exp:** **CCV:**

Name on Card:

Name of Authorized Individual (please print):

Billing Address: **Contact Person:**

Phone Number:

Contact Email:

Fax Number:

Signature X: **Date:**

Please print and sign

By signing, I authorize Vertisis Custom Pharmacy to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount invoiced as requested by provider or provider's office only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Rep Code:

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Pharmacy Services Provider Agreement

Doctor/ Facility Name:

I, , authorize Vertisis Custom Pharmacy LLC, and any other pharmacies owned by Vertisis Custom Pharmacy LLC (referred to in this agreement as the "Pharmacy") to provide medications and associated products and services to the above-named Doctor and or Facility. I certify that I have the legal authority to sign this agreement on behalf of said Doctor and or Facility. I understand that by signing this agreement I will become responsible to pay the usual and customary fee for all medications, products and services provided to the Doctor and or Facility by the Pharmacy at the direction of the facility administration and staff and attending physician(s). If I disagree with any medication, product or service directed by the facility or an attending physician, I will contact them and resolve the issue(s) and ask them to provide different written direction to the Pharmacy. I acknowledge and agree that the Pharmacy provides medications, products or services based upon the most current written direction received by it.

For patients receiving benefits from an insurance company, I am aware that the Pharmacy Does Not bill any insurance for any of its products and or services and the doctor and or Facility accepts full financial responsibility for the medication it prescribes from the Pharmacy. I also understand that not all medications and products that the Pharmacy may compound are FDA approved. I understand that it is my responsibility to consult with the proper overseeing medical licensure board to fully understand my scope of practice.

Initials:

I also understand that the Pharmacy will bill me on a regular basis (normally per order) for all charges for which I am responsible on behalf of the Patient. The invoice will show all charges billed, payments received, and any adjustments required to the patient's account over the previous billing period, plus any balance forward. I agree to pay the Pharmacy in full before my prescription has shipped. I acknowledge and agree that any order / prescription that is not canceled within 24 hours of the expected delivery date will result in a charge of 30% of the retail cost of the prescription. If the Pharmacy is required to pursue legal action to collect any balance due from me on behalf of the Doctor and or Facility, I agree to pay reasonable attorney and collection agency fees and costs incurred in collecting any amounts due and owing hereunder.

Initials:

I understand that Arizona state statute and federal antikickback rules prohibit the mark up in price of custom compounded medications by a prescriber or facility. I understand the Pharmacy will provide the Doctor and or Facility a duplicate copy of the price, dosage form, drug name and strength for the prescribed medication which should be provide to the patient, patient representative, and or third party payer. I understand that the Doctor and or Facility can in no way mark-up the price of the medication for a patient.

Initials:

I also understand that the Pharmacy has the option to discontinue providing additional medications, products or services to the above-named Doctor and or Facility at any time for any reason, regardless of whether the Pharmacy still provides medications, products or services to other Doctor and or Facility.

I understand that the Pharmacy can provide for regular automatic payments from an established checking or savings account or to a credit card. If I elect an automated payment method, I will sign a separate authorization form, but understand that the terms and conditions of this agreement will still apply.

Name of Authorized Individual (please print):

Address: **Contact Person:**

Phone Number:

Contact Email:

Fax Number:

Signature X: **Date:**

Please print and sign

(By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.)

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Pharmacy Informed
Consent Statement Form

Doctor/ Facility Name: _____

I, _____, understand that 42 U.S.C. § 1320a-7b (also known as the federal Anti-Kickback Statute ("AKS")) is a criminal statute that prohibits the willful exchange of anything of value from a health care business, or individual health care provider, to induce the referral, purchase, or use of a product/service that is eligible for payment by a federal health care program (e.g., Medicare, Medicaid, TRICARE, etc.). When the exchange of anything of value (referred to as "remuneration" in the statute) is offered to a federal beneficiary purposefully to induce or reward the beneficiary to purchase or consume a service or product payable by a federal health care program, the AKS is violated. The AKS defines "remuneration" as the exchange of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five (5) years, or both. Conviction will also lead to the offending provider being automatically excluded from participation in federal health programs, including Medicare and Medicaid.

I also understand that according to Ariz. Rev. Stat. § 32.1901.01(B)(24) Arizona statutes prohibit the payment of rebates to a prescriber for any prescription regardless of the payer source.

Vertisis Custom Pharmacy LLC, and any other pharmacies owned by Vertisis Custom Pharmacy LLC (referred to in this agreement as the "Pharmacy") require its prescribers to include in their consent documents the following statement that notifies its patients of their right to direct their pharmacy needs to any pharmacy.

To be placed in patient's consent documents:

"I understand that I have the ability and it is my right to be able to select / direct which pharmacy my prescriber uses to fill my medication orders."

I understand that it is my responsibility to include the above statement inside of my patient's consent documents. If for some reason the consent statement is not included in the patient's consent documents or the patient does not sign the consent documents, I understand that the Pharmacy cannot and will not supply any medications for that patient. I understand it is my responsibly to make sure every patient signs a copy of the above consent statement.

Initials: _____

Name of Authorized Individual (please print): _____

Address: _____ **Contact Person:** _____

_____ **Phone Number:** _____

_____ **Contact Email:** _____

_____ **Fax Number:** _____

Signature X: _____ **Date:** _____

Please print and sign

(By signing, I acknowledge that I have read and understand the terms and conditions of this Provider Agreement.)