

Account Information

Print & Fax to: 877-447-7977

officeorders@centraldrugsrx.com



Date:

Business Name

Owner (first last, title)

Physician's Name

Address

City **State** **Zip Code**

Phone **FAX**

Alt Phone **Alt FAX**

email

Please Include:

- Copy of State license
- Copy of DEA License

Information

Primary Specialty:

State License #

NPI #

How did you hear about Central Drugs?

Primary Contact & Ext #

Ship to Address (if different than billing address)

Address

City **State** **Zip Code**

Charge Card Authorization

Name as it appears on the card

Billing address as it appears on your credit card statement Same as above

Address: **Suite #**

City: **State:** **Zip:**

VISA MASTERCARD American Express

Card Number:

Expiration Date: **CVV2 Code**

Signature of cardholder: **Date:**

Print all authorized person(s):

Name:

Name:

Name:

By signing below you state that you understand and agree to allow Central Drugs to bill to the credit card, as listed above, to pay for the costs of all ordered prescription medication. Thank you for your assistance in keeping the integrity of our records and helping us to continue to provide you with superior service.

Physician's Statement - The Doctor Patient Relationship

We understand in some cases, that the patient and the prescribing physician may reside in different states. In order to ensure that all prescriptions received by Central Drugs are pursuant to a valid doctor/patient relationship, we require that our prescribing physicians agree that the following elements are satisfied prior to sending us a prescription. For purposes of state law, many state authorities, with the endorsement of medical societies, consider the existence of the following four elements the indication that a legitimate doctor/patient relationship has been established:

1. A patient has a medical complaint.
2. A medical history has been taken and a physical examination has been performed.
3. Some logical connection exists between the medical complaint, the medical history, the physical examination and the drug prescribed.
4. If you are nurse practitioner or physician assistant, you are hereby acknowledging you have a valid collaborative practice agreement with a supervising physician.

I agree that all prescriptions sent to Central Drugs will meet the criteria above. I agree that there is no other agreement written, oral or otherwise that negates this one. I understand that Internet diagnosing without a face to face appointment is illegal. I have seen my patients in my office and have performed a physical exam.

All orders purporting to be a prescription will be prescribed within the meaning and intent of section 309 of the Act (21 U.S.C. 829) according to the section 1306.04 in Code Of Federal Regulation.

Physician's Signature : **Date:**

Please fax (877-447-7977) a copy of your: DEA License & State License