10901 Roosevelt Blvd. N. Suite #1200C
St. Petersburg, FL. 33716

Account Setup and Credit Card Authorization Form

Account Name	
Street Address	
City, State Zip Code	
Phone #/Email Address	

Products to be ordered under this account

❑ ICI (trimix/Bimix)	❑ Mitomycin/DMSO
❑ PDE-5 (sildenafil, tadalafil)	❑ Test Doses
❑ Testosterone (cypionate, gel)	❑ Other: ___________________________

Prescribers authorized to order under this account

Full Name	NPI#

To add providers or update product preferences, please email your territory manager or to the PharmaLabs billing department directly at: bcheek@plabrx.com

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Order Processing Information			
Ship to Method	❑ Patient (address to be provided per Rx) ❑ Office (address below)		
Office Ship Street Address			
Office Ship City, State Zip			
Day of Week Orders Should Arrive *(Pick One)*	❑ Tue ❑ Wed ❑ Thur ❑ Fri		
Practice Contact			
Practice Contact Phone #			
Practice Contact Email			

I (we) hereby authorize PharmaLabs to make recurring charges to my payment method below. All records are kept in a secure file accessible to authorized personnel only. All payments are due upon receipt and unpaid balances may lead to late payment penalties and account closure.

Payment Information			
Payment Method	❑ Visa ❑ Mastercard ❑ American Express ❑ Discover	❑ Invoice: *Enter billing address below for invoice to be mailed to. Payment due on receipt of invoice*	
Card Number			
Expiration Date and CVV Code			
Cardholder Signature			
Cardholder Name			
Billing Street			
Billing City, State, and Zip			
Billing Email *(for receipts/statements)*			

Charges processed as:
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Shipping & Handling

It is understood that PharmaLabs utilizes FedEx and USPS as methods of shipping. PharmaLabs will choose the most affordable shipping vendor and method unless the “RUSH” preference is noted on the prescription in which case the method will always be Fedex standard overnight. See shipping rate sheet for the most up to date pricing.

Signature required delivery will be defaulted. It is understood that by choosing non-signature required delivery, the physician and/or patient is accepting full responsibility regarding the delivery of the prescription. In the event the shipping vendor indicates a successful delivery for a non-signature required package and the recipient states the package was not delivered, the patient and/or clinic will be responsible for payment of a replacement order.

menMD must be notified within 48 hours of receipt of goods if any 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.

Provider Agreement

This Provider Agreement is by and between PhamaLabs and________________ “Prescriber” wherein each of the parties agrees as follows:

1. Prescriber acknowledges this purchase is from PharmaLabs for a specific patient of Prescriber’s practice.
2. PharmaLabs agrees that it provides patient specific compounded preparations to the Prescriber practice subject to the terms of this Provider Agreement.
3. Each of the Parties agree to the following terms:
    i. Any patient specific compounded preparations prepared by PhamaLabs are received by Prescriber as an agent of the patient and shall not be redispensed to the patient of the Prescriber or dispensed to any third party or entity;
    ii. The Prescriber will provide all packaged literature to the patient for the medication usage instruction and for the reporting of any adverse reaction of complaint in order to facilitate any recall of batches of compounded preparations.
4. PharmaLabs maintains a record of all patient specific compounded preparations distributed to the Prescriber as an agent of the patient and such records shall include the date of the prescription, name, address, and phone number of the Prescriber who ordered the preparation and the name, strength and quantity of the preparation ordered and the LOT number of each preparation.

If you understand and agree to all the terms herein, please sign below prior to submission of Provider Agreement.

____

(Authorized Signature) (Date)

Charges processed as:
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