CUSTOMER AGREEMENT FORMS

NOTE: Hartley medical is a HIPAA compliant company. All information is strictly confidential.

In order to promptly process your order, we kindly request for you to review and return the following forms:

- ☐ Client Information – Part 1
- ☐ Billing and Credit Information – Part 2
- ☐ New Physician Form – Part 3
- ☐ New Patient Form -Part 4 (Or Physicians Demographic Page)
- ☐ Credit Card Authorization Form – Part 5 (Optional)

These forms can be returned via:

- Fax: 800.648.8550
- E-mail: fax@hartleymedical.com
- Mail: Hartley Medical Center, 113 W. Victoria Street, Long Beach, Ca 90805

The "NEW PATIENT FORM" (Part4) must be filled out for each patient that is new to Hartley Medical, prior to us dispensing their first medication. Any patient demographic form(s) from your facility/physician(s) will be accepted if it contains all the information requested on Part 4 form. If this information is missing or incomplete, there will be a delay in the processing of your order while we attempt to retrieve vital information.

Credit card information should be sent directly to our accounting department via our secured fax line at 888.399.7846

Hartley Medical Center Pharmacy Inc (Hartley Medical) policies require that we receive customer information forms prior to establishing a new account or reactivating an existing one, if the facility has not ordered in more than six months.

To reactivate your account please send all inquiries to nadia@hartleymedical.com

Hartley Medical looks forward to building a long-term relationship with your company. We appreciate your business. Should you have any questions or concerns please contact Hartley Medical 888.671.2888

- Jeff – Business Development Ext 604
- Nadia – Financial Services Ext 620

Customer Information

New/Returning Client Form- PART 1

NOTE: HARTLEY MEDICAL IS A HIPAA COMPLIANT COMPANY. ALL INFORMATION IS STRICTLY CONFIDENTIAL.
**** ANY UPDATES TO THE ACCOUNT SHOULD BE SUBMITTED IN WRITING. ****

BUSINESS INFORMATION: (no abbreviations)

Company Name: _____

Address:_____ Suite # _____

City:_____ State: _____Zip: _____

Office #: _____ Fax#: _____

CONTACT/PURCHASER INFORMATION:

Name/Title: _____

Office# Ext. _____ Direct Line: _____ Cell Phone: _____

Email (optional): _____

Preferred Way of Contact: ☐ Business Phone ☐ Cell Phone ☐ Text Message ☐ Email

SHIPPING INFORMATION: (no abbreviations)

Please attach an additional sheet if you should have more than one facility. Packages will not be delivered to home addresses. If email is included, our courier service will provide information when your package is shipped.

Facility Name: _____

Attention: _____ Title: _____

Address:_____ Suite # _____

City:_____ State: _____Zip: _____

Office# Ext. _____ Direct Line: _____ Cell Phone: _____

Email (optional): _____

ACCOUNTS PAYABLE: (no abbreviations)

Company Name (<u>if offsite company</u> handles your accounts payable):

_____ ☐ Same as Above

Address:_____ Suite # _____

City:_____ State: _____Zip: _____

A/P Contact Name: _____

Office# Ext. _____ Direct Line: _____ Cell Phone: _____

Email (optional): _____

Preferred Way of Contact: ☐ Business Phone ☐ Cell Phone ☐ Text Message ☐ Email

AGREEMENT FOR CREDIT

New/Returning Client Form - PART 2

BUSINESS CONTACT INFORMATION		
Tax ID:	**Type of Organization**	**Payment Method:**
Company's Legal Name:	☐ Sole Proprietorship	☐ Check
	☐ Partnership	☐ Credit Card
Office # Fax #	☐ Corporation	☐ Cash
Registered Company Address:	☐ Other	☐ ACH

BUSINESS AND CREDIT INFORAMTION	
DBA Name:	BANK INFORMATION
Primary Business Address:	Name:
	Email:
City:	Office #
State: Zip:	Fax #
Direct #	
Email:	Account Number:
How long at current address?	Type of Account: ☐ Savings ☐ Checking ☐ Other

AGREEMENT

The person(s) signing this Credit form warrants that the above information is complete and accurate and hereby agrees to the following terms and conditions: 1. The undersigned agrees to immediately notify Hartley Medical Center Pharmacy Inc of any changes in ownership, or business name of the entity listed above, within 15 days of the change. 2. This document will be as effective in a photocopy or a fax form as in the original. 3. The undersigned acknowledges that Hartley Medical Center Pharmacy Inc may limit or discontinue credit at its sole discretion and that the continued extension of credit may require additional information from time to time. 4. The undersigned warrants that they have full authority to sign this agreement and obligate the entity hereunder. 5. The undersigned agrees that if all invoices that of all invoices are not paid when due, they will accrue late charges at the rate of 18% per annum or the maximum rate allowed by law, whichever is less. If it is necessary to take legal action, jurisdiction should be in the State of California and the venue shall be the County of Los Angeles. The undersigned agrees to reimburse Hartley Medical Center Pharmacy, Inc for any attorney fees, court costs or other costs of collections which may be incurred in its efforts to collect any past due debts. 6. All credit terms will be released to you upon credit approval. 7. The undersigned hereby consent(s) to Hartley Medical Center Pharmacy Inc.'s use of business consumer credit reports on the undersigned in order to further evaluate the credit worthiness of the undersigned as principal, proprietor, and/or guarantor in connection with the extension of business credit as completed by the credit application. I hereby authorize Hartley Medical Center Pharmacy Inc to utilize a business credit report on the undersigned from time to time in connection with the extension or continuation of the business credit represented by this credit application. The undersigned individual(s) hereby knowingly consent to the use of such credit reports consistent with Federal Fair Credit Reporting Act as contained in U.S.C. @1681 et Seq.

AUTHORIZED SIGNATURES

Signature	Signature
Name & Title	Name & Title
Date	Date

Authorized Prescribers Information

New/Returning Client Form- PART 3

NOTE: HARTLEY MEDICAL IS A HIPAA COMPLIANT COMPANY. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Company Name: _____

PRESCRIBER #1

Authorized Prescribers Name: _____

Title (check one): ☐MD ☐PA ☐NP ☐PharmD ☐DO ☐ARPN ☐RN ☐Other _____

Address: _____

City:_____ State: _____Zip: _____

DEA Number: _____ Exp Date: _____

State License Number: _____ Exp Date: _____

NPI Number: _____Signature: _____

PRESCRIBER #2

Authorized Prescribers Name: _____

Title (check one): ☐MD ☐PA ☐NP ☐PharmD ☐DO ☐ARPN ☐RN ☐Other _____

Address: _____

City:_____ State: _____Zip: _____

DEA Number: _____ Exp Date: _____

State License Number: _____ Exp Date: _____

NPI Number: _____Signature: _____

PRESCRIBER #3

Authorized Prescribers Name: _____

Title (check one): ☐MD ☐PA ☐NP ☐PharmD ☐DO ☐ARPN ☐RN ☐Other _____

Address: _____

City:_____ State: _____Zip: _____

DEA Number: _____ Exp Date: _____

State License Number: _____ Exp Date: _____

NPI Number: _____Signature: _____

PRESCRIBER #4

Authorized Prescribers Name: _____

Title (check one): ☐MD ☐PA ☐NP ☐PharmD ☐DO ☐ARPN ☐RN ☐Other _____

Address: _____

City:_____ State: _____Zip: _____

DEA Number: _____ Exp Date: _____

State License Number: _____ Exp Date: _____

NPI Number: _____Signature: _____

PATIENT INFORMATION

New/Returning Client Form- PART 4

NOTE: HARTLEY MEDICAL IS A HIPAA COMPLIANT COMPANY. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

According to the Food and Drug Administration/ Board of Pharmacy, we must have all information below filled out for all patients receiving medications or pharmaceuticals. Upon completion, please fax the required information to Hartley Medical at 800.648.8550. If you have a patient information sheet containing all the required information, this sheet may be substituted.

PHYSICIAN/FACILITY RESPONSIBILITIES: Said physician or facility will be responsible for payment of patient's medication unless alternative arrangements are made prior to services rendered.

INSURANCE/WORKERS COMPENSATION: We do not currently bill for insurance.

SELF-PAY: All payments are required prior to processing order(s). Our accounting department will contact the patient for payment information. Please advise your patient that Hartley Medical will be contacting them. While payment by credit card is preferred, we will accept payment by check. Prescriptions for patients who prefer to pay by check will need to be received two weeks prior to appointment, to allow Hartley time for invoicing and the patient time to mail their check.

Medical Record #: _____

Patient Name: _____

Address (No PO Box): _____

City:_____ State: _____Zip: _____

Home Phone: _____ Cell Number: _____

Email: _____ Date of Birth: _____/_____/_____

Height: _____Weight: _____ Sex: ☐ Male ☐ Female

Current Medication: _____

_____

Drug Allergies: _____

ICD 10 Diagnosis Code: _____, _____, _____, _____, _____

☐ Minor Child (under 18) ☐Guardian of Patient

Guardians Name: _____

Relationship to Patient: ☐Mother ☐Father ☐Grandparent ☐Stepparent ☐ Other _____

Home Phone: _____ Cell Number: _____

CREDIT CARD AUTHORIZATION FORM

New/Returning Client Form- PART 5

FOR YOUR SECURITY PLEASE FAX THE COMPLETED CREDIT CARD FORM TO OUR ACCOUNTS FAX AT 888.399.7846

Company Name: _____

CREDIT CARD BILLING INFORMATION:

Cardholder Name: _____

Address: _____

City:_____ State: _____Zip: _____

CREDIT CARD TYPE:

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ American Express

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____

Card Identification Number (last 3 digits located on the back of Visa/Master Card or 4 digits on the front of American Express)

Security Code: _____

PLEASE CHECK A BOX:

☐ One Time Authorization – I hereby authorize Hartley Medical Center Pharmacy Inc. (Hartley Medical) to charge the above credit card for $_____.

☐ One Time Authorization – I hereby authorize Hartley Medical to charge the above credit card for Invoice(s) 1._____ 2._____ 3._____ 4._____

☐ Recurring Billing – (Keep credit card on file for future purchases) I hereby authorize Hartley Medical to charge the above listed credit card on a periodic basis for the amount due under my contract. This recurring payment authorization/periodic charge shall remain in effect until cancelled by me in writing or until the credit card expires.

AUTHORIZATION:

I hereby authorize Hartley Medical Center Pharmacy Inc. to charge my credit card as described above. I understand that any cancellation must be made in writing. I will not dispute Hartley Medical recurring billing with my credit card issuer, as long as the amount in question was for services rendered prior to my canceling my account in the manner required. I guarantee and warrant that I am the legal cardholder of this credit card and that I am legally authorized to enter into this agreement with Hartley Medical Center Pharmacy Inc.

_____ _____

Print Full Name / Signature **Date**