AGREEMENT FOR PURCHASE OF COMPOUNDED OFFICE USE MEDICATION

The practitioner agrees to purchase compounded medications for Office Use from Vitamindrip® Pharmacy under the following guidelines as required per Florida rule 64B16-27.700.

1. The compounded drug may only be administered to the patient and may not be dispensed to the patient or sold to any other person or entity;

2. The practitioner shall include on the patient's chart, medication order, or medication administration record the lot number and the beyond-use-date of any compounded drug administered to the patient that was provided by the pharmacy;

3. The practitioner will provide notification to the patient for the reporting of any adverse reaction or complaint in order to facilitate any recall of batches of compounded drugs.

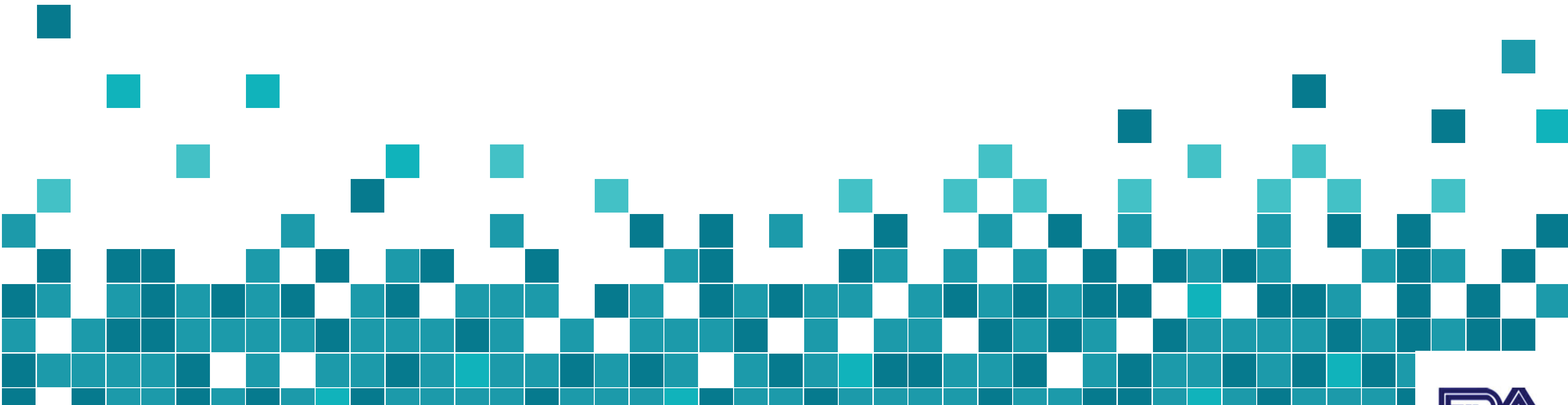
Practitioner Name: ____

Address: ____

City, State, Zip: ____

Phone Number: ____

Signature: ________________________ ***Date:*** __________________



vitamindrip® ACCOUNT SETUP Your life, just **better.**™

PHYSICIAN'S OFFICE CONTACT INFORMATION

Date: ________________________________

Physician Name: ____

Business Name: ____________________________ **Office Manager:** _______________

Physical Address: ____

Office Phone: ____________________________ **Office Fax:** __________________

Other phone: _______________________ **Email (for invoices):** __________________

Dear Doctor:
We understand that in some cases, the patient and the prescribing physician may reside in different states. In order to ensure that all prescriptions received by Vitamindrip® 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 as an indication that a legitimate doctor/patient relationship has been established:

- *A patient has a medical complaint;*
- *A medical history has been taken;*
- *A physical, in person, examination has been performed by the prescribing physician, and*
- *Some logical connection exists between the medical complaint, the medical history, the physical examination, and the drug prescribed.*
- *All controlled medication ordered as "office use" will come clearly marked as "office use" and "not for resale". These medications are provided for the physician to administer to the patient in the office ONLY.*

I ______________________________________,agree that all prescriptions sent to Vitamindrip® meet the criteria above. I agree that there is no other agreement written, oral or otherwise that negates this one.

Physician Signature: ______________________________ *Date:* __________________________

FDA REGISTERED

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Recurring Credit Card Charge Authorization Form

I (we) hereby authorize VITAMINDRIP, INC. to make recurring charges to my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error.

This authority will remain in effect until VITAMINDRIP, INC. is notified by me (us) in writing to cancel it in such time as to afford VITAMINDRIP, INC. and/or Credit Card Company a reasonable opportunity to act on it.

All records are kept in a secure file electronically password protected and accessible to authorized personnel only.

Clinic Information

Clinic Name:	Provider Name:		
Street:	City:	State:	Zip:
Phone:	Fax:		
DEA #	State License #:		
Email:	Website:		
Preferred Method of Contact:	Phone	Fax	Email

Billing Information

Card Type:	☐ Visa	☐ MasterCard	☐ Amex	☐ Discover
Card Holder's Name:				
Card Number:		Exp. Date:	CCV#:	
Billing Info: (if different from above)				
Billing Phone:		Signature:		

It is understood that VITAMINDRIP, INC. utilizes UPS, FedEx and USPS as methods of shipping and will choose the specific shipping vendor unless a specific shipping preference is noted on the prescription. Signature required delivery will be defaulted if specific shipping instructions are not indicated on the prescription or if previously discussed and agreed upon. 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. VITAMINDRIP, INC. 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.

Billing & Shipping Instructions

Bill to: ☐ Clinic ☐ Patient	Ship to: ☐ Clinic ☐ Patient
Preferred Shipping: ☐ Ground ☐ 2nd Day ☐ Overnight	