New Medical Practice Form

Fax Completed Form To 866-635-2329

Name of Practice: ____________________

Physical Address: ____________________

City: ____________________ **State:** ____ **Zip:** ____________

Phone: ____________________ **FAX:** ____________________

Days and Hours of Operation: ❑ **Mon** ______ ❑ **Tues** ______ ❑ **Wed** ______ ❑ **Thur** ______ ❑ **Fri** ______

Days or Times Packages Cannot Be Received: ____________________

Primary Contact: ____________________ **Primary Contact Email:** ____________________

Shipping Contact: ____________________ **Shipping Contact Email:** ____________________

Billing Contact: ____________________ **Billing Contact Email:** ____________________

Prescriber's Information

Name: ____________________ **NPI #** ____________________ **DEA #** ____________________

Name: ____________________ **NPI #** ____________________ **DEA #** ____________________

Name: ____________________ **NPI #** ____________________ **DEA #** ____________________

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6095 Pine Mountain Rd., NW Suite 108
Kennesaw, GA 30152
Tel:(800)547-1399 Fax: (866)635-2329
www.innovationcompounding.com

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Billing Information

Business Tax ID #: ______________________________

Billing Address Same as Physical Address? ❑ **Yes** ❑ **No (If no, please complete below)**

Billing Address: ____

City: _____________________________________ **State:** ____ **Zip:** __________________

A Valid Credit Card Must Be On File At All Times

Card #: _____________________________________ **Exp. Date:** __________ **CVS Code:** __________________

Authorization

❑ **I authorize Innovation Compounding to charge all invoices directly to my credit card at the time of purchase. I understand no shipments will be shipped until my credit card transaction is complete.**

Signature: _____________________________ **Title:** _____________________________

Name *(print)*: _____________________________ **Date:** _____________________________

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INNOVATION COMPOUNDING
Custom Medications. Optimal Outcomes.

Physician's Agreement for Compounded Preparations

After completing this form, please fax to 866-635-2329

A SEPARATE FORM MUST BE COMPLETED FOR EACH PRESCRIBER

Date: ____________________

This agreement indicates that Innovation Compounding, located at 6095 Pine Mountain Rd., NW - Suite 108; Kennesaw, GA 30152, hereafter known as “Pharmacy,” will provide compounded preparations for administration to patients in the medical office, hereafter known as "Practice," either by the Physician personally or by an authorized person under the Physician’s direct and immediate supervision, hereafter known as "Physician" at the address:

Practice Name: ____

Physicians Name: ____

Address: ____

City: ______________________________ State: _______ Zip:__________________

Office Phone: ______________________________

Physician Requirements:

1.) These compounded preparations may only be administered to the patient for which the medication was prescribed, and may not be sold to any other person or entity. When the compounded preparation is administered, physician agrees to indicate on the patient’s medical chart the lot number and beyond-use date (BUD) of the preparation used.
2.) Physician is licensed in the same state as Practice.
3.) Physician is actively monitoring the care of patients, either through direct patient-care or oversight of appropriately trained personnel.
4.) If Physician terminates relationship with Practice, Physician will immediately notify Pharmacy the date of termination.

Pharmacy Requirements:

The compounding of preparations will include the following activities by the Pharmacy: verification of the source of raw materials to be used; compliance with applicable United States Pharmacopoeia guidelines (including testing requirements), the Health Insurance Portability and Accountability Act of 1996, and all applicable competency and accrediting standards as determined by the Georgia State Board of Pharmacy as well as the Board of Pharmacy in the Practice's state residence. Pharmacy agrees to record the lot numbers of compounded preparation supplied for office-use so that, in the event a recall of the preparation is required, Pharmacy can notify Physician of the recall and can facilitate contacting any patients who received the product. In such an event, Pharmacy’s existing protocols for notifying patients, quarantine of the product (if applicable), and/or recall will be followed.

Any adverse reactions or complaints may be submitted by the patient to either Pharmacy or Physician; in the event a report is made, the entity receiving the report will forward a copy to the other entity. If patient harm is suspected or confirmed to be due to a preparation compounded by Pharmacy, Pharmacy will notify the Georgia State Board of Pharmacy, the Board of Pharmacy where the patient resides, and the FDA.

AGREED UPON BY:

Physicians Name: ______________________________

NPI#: ______________________________

DEA#: ______________________________

State License#: ______________________________

Physician Signature: ______________________________

For Pharmacy: SHAWN HODGES, PHARMD

Signature: ______________________________