New Account Setup Packet

Please complete attached forms and fax or e-mail to ASP Cares at your convenience.

Packet Checklist:

☐ Credit Card Charge Authorization Form

☐ Agreement for Purchase of Compounded Office Use Medication

☐ Practitioner Statement Regarding Office Visit Requirements

☐ Copy of Practitioner's Active State License

☐ Copy of Active DEA License (if ordering controlled substances)

To electronically fill out account setup packet:

1. Open PDF in Adobe Acrobat Reader.
2. Click Fill & Sign on the right windowpane.
3. To sign, click on the Sign icon to create a digital image of your signature.

FDA REGISTERED
503B Outsourcing Facility

Fax completed form to 1.888.413.1021 or e-mail to 503B@aspcares.com.

Sales Representative Name: _____

ASP CARES
2414 Babcock Road Suite 106
San Antonio, TX 78229
Ph. 888.413.1021 Fax 888.413.1021
www.aspcares.com

Credit Card Charge Authorization Form

I hereby authorize ASP Cares to make recurring charges to the credit card listed below, and, if necessary, initiate adjustments for any transactions credited or debited in error. This authorization will remain in effect until ASP Cares is notified in writing to cancel it. ASP Cares will bill on the date of shipment unless other terms have been agreed upon.

Facility Name: _____

Facility Address: _____

City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name on Card: _____

☐ Billing Address is the same as Facility Address

Billing Address: _____

City, State, Zip: _____

Card Type: ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **Amex**

Card Number: _____ Exp Date: _____

Cardholder Signature: _____ Date: _____

Fax completed form to 1.888.413.1021 or e-mail to 503B@aspcares.com.

ASP CARES
2414 Babcock Road Suite 106
San Antonio, TX 78229
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Agreement for Purchase of Compounded Office Use Medication

The practitioner agrees to purchase compounded medications for office use from ASP Cares under the following guidelines:

1. The compounded medication may only be administered to the patient and may not be sold to the patient or to any other person or entity.
2. The practitioner shall record the lot number and beyond-use-date of any compounded medication administered to the patient on the patient's chart, medication order, or medication administration record in order to facilitate any recalls associated with the compounded medication.
3. The practitioner shall provide the patient instructions on reporting any adverse events or complaints associated with the compounded medication.

Practitioner Statement Regarding Office Visit Requirements

In order to ensure that all orders received by ASP Cares are pursuant to a valid practitioner / patient relationship, we require that our practitioners agree that the following elements are satisfied prior to sending an order. The existence of these elements is an indication that a legitimate practitioner / patient relationship has been established:

1. The patient has a medical need; a medical history has been taken; a physical examination has been performed.
2. A logical connection exists between the medical need, the medical history, the physical examination, and the medication ordered.
3. These medications are provided for *administration* to the patient. All medications ordered for office use will come clearly marked "Office Use Only. Not For Resale."

Facility Name: _____

Facility Address: _____

City, State, Zip: _____

Practitioner Name: _____

License #: _____ NPI: _____ DEA #: _____

Supervising Physician (if applicable): _____

License #: _____ NPI: _____ DEA #: _____

Practitioner Signature: _____ Date: _____

Fax completed form to 1.888.413.1021 or e-mail to 503B@aspcares.com.