

MasterPharm, LLC is HIPAA compliant. All information is kept strictly confidential.

**Customer Information**

Date \_\_\_\_\_

Name of Business \_\_\_\_\_  
*(No abbreviations)*

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact person \_\_\_\_\_ Email \_\_\_\_\_

Type of Organization: Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ LLC \_\_\_\_\_ Other \_\_\_\_\_

Date business established \_\_\_\_\_ Estimated annual volume of business \$ \_\_\_\_\_

**Billing Information** *(if different from above)*

Billing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

A/P Contact \_\_\_\_\_ A/P Email \_\_\_\_\_

A/P Phone \_\_\_\_\_ A/P Fax \_\_\_\_\_

**Shipping Information** *(Please use another sheet for multiple offices)*

Clinic/Hospital or Physician's office \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Dept \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax \_\_\_\_\_

Special Shipping instructions: \_\_\_\_\_

**Physician Information** *(Please use another sheet for additional physicians)*

Physician Name: \_\_\_\_\_ DEA # \_\_\_\_\_

Physician Name: \_\_\_\_\_ DEA # \_\_\_\_\_

Physician Name: \_\_\_\_\_ DEA # \_\_\_\_\_

Physician Name: \_\_\_\_\_ DEA # \_\_\_\_\_

\*\*\* Note that all medications are compounded pursuant to the physician's prescription. \*\*\*

Name of Business \_\_\_\_\_ Date \_\_\_\_\_

Federal Tax ID# \_\_\_\_\_ Duns # \_\_\_\_\_

Bank Reference: Bank Name \_\_\_\_\_ Bank Account \_\_\_\_\_

Bank Contact \_\_\_\_\_ Phone \_\_\_\_\_

Business References: (List 3)

1. Company Name \_\_\_\_\_ Account # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

2. Company Name \_\_\_\_\_ Account # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

3. Company Name \_\_\_\_\_ Account # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

<p><b>Choice of Billing</b> (Check all that apply)</p> <input type="checkbox"/> Monthly Summary <input type="checkbox"/> Invoice per order PO # required on original order? Yes ___ No ___ All customers will receive a month-end statement of open invoices	<p><b>Payment Method</b> (Check one option below)</p> <input type="checkbox"/> Upon receipt of Invoice <input type="checkbox"/> Credit Card (charged at time of order) <i>Your credit card is kept on file and a receipt will be sent stamped "paid."</i> <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> AMEX <input type="checkbox"/> Discover
<p><b>Payment Terms:</b> All payments are due 30 days from date of invoice to:                  MasterPharm, LLC                  115-06 Liberty Avenue, Richmond Hill, NY 11419</p>	<p>Credit Card # _____ Exp. Date _____</p> <p>_____                  Authorized Cardholder's Signature</p>

The person(s) signing this Credit Application, Terms & Conditions 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 MasterPharm, LLC of any change in ownership, form or business name of the entity.
2. This document will be as effective in photocopy or fax form as in the original.
3. The undersigned acknowledges that MasterPharm LLC 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 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 shall be the State of Florida and the venue shall be Hillsborough County, Florida. The undersigned agrees to reimburse MasterPharm, LLC for any attorney fees, court costs or other costs of collection which may be incurred in its efforts to collect any past due debts.

\_\_\_\_\_  
*Signature* *Date*

\_\_\_\_\_  
*Signature* *Date*

\_\_\_\_\_  
*Printed Name/Title*

\_\_\_\_\_  
*Printed Name/Title*