wells pharmacy network
superior science & service

Account Setup Form

Fax to: 561-223-3885 or email to: newaccount@wellsrx.com

Submission of this form confirms your request for payment by credit card. You agree to pay any and all amounts charged by Wells Pharmacy Network to your credit card as specified below. In addition, you authorize Wells Pharmacy Network to obtain approval from the credit card company listed below.

I hereby authorize Wells Pharmacy Network to charge my credit card account as listed below. I affirm that I am at least 18 years old and legally authorized to use the credit card account and number listed below. In addition, I understand and agree that any charges made to the account listed below are non refundable and agree to pay in accordance to my agreement with the specified card company, any such amounts charged by me both in the past and henceforth. Furthermore, I agree to hold Wells Pharmacy Network completely and fully harmless from and against all claims of any type or nature whatsoever resulting from any charges made to said credit card account payment and will be billed to the credit card depicted below.

Sales Rep. or Business Mgr:_____ ☐ New Account ☐ Existing Account

Office Information

Prescriber* Name _____ ▶ Signature _____

DEA# (required) _____ State License # _____

Practice /Clinic Name _____ NPI # _____

Is this the Primary Location? ☐ (You must indicate which location is the prescriber's primary location.)

Address _____

City_____ State _____ Zip _____

Phone _____ Fax _____

Office Contact if Other Than Physician _____ Phone _____

Email (For order tracking) _____ Website_____

Register me for WellsPx3 ☐ Online Ordering ☐ Order Management

*If Prescriber is other than a Physician, please complete Dispense Authorization on page 2

Payment Information

Cardholder Name _____ Phone _____

Signature _____

Card Number _____ Exp. Date_____ CVV Code _____

Credit Card Billing Address _____

City_____ State _____ Zip _____

_____ (Please Initial) I hereby authorize Wells Pharmacy Network to charge the above credit card through their online credit card processing system for all physicians affiliated with this practice.

The card holder specified above agrees that Well Pharmacy Network will automatically bill the subscriber's credit card upon completion of the prescription order unless other arrangements have been made specific to the above subscriber's account.

▶ Signature _____ Date _____

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Patient Counseling

Wells Pharmacy Network is committed to compliance with state and federal laws. We are aware that some patients may reside in states differing from their prescribing physician. To ensure that all prescriptions received by Wells Pharmacy Network are pursuant to a valid patient/doctor relationship, we require that the prescribing physician agree that the following elements are met prior to sending us a prescription.

1. A documented patient evaluation, including history and physical examination, adequate to establish the diagnosis for which any drug is prescribed.
2. Sufficient dialogue between the physician and the patient regarding treatment options and the risks and benefits of treatment.
3. Contemporaneous medical records are maintained.

I _____ , agree that all prescriptions sent to Wells Pharmacy Network have met the criteria above, or I am in full compliance with state and federal laws regarding a valid patient/doctor relationship.

Physician Name _____

Physician Signature _____

Date: _____

Dispensing Authorization

Many states allow advanced practice nurses, physician assistants, or other designated members of the health care team, to prescribe medications. Wells Pharmacy Network is delighted to partner with all prescribers, to achieve optimum outcomes for our patients. If your state requires a written agreement between a designated prescriber, working under the authority of a physician, we need a copy of the document that provides that authority for our records.

If you have independent prescribing authority, then no document is needed. However, some states with independent prescribing authority have limitations on prescribing controlled substances in the law, and we will adhere to those limitations. If you are required to have a dispensing authorization agreement, please ensure that the authority extends to controlled substances, if you are prescribing one of our testosterone products (or any other controlled substance.)

As always, please include your license number, DEA number, and NPI number on your prescriptions, as well as your office address and phone number.

Please attach Prescribing Authority Document

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Multiple Location Practices

Office 2 Information

Prescriber Name _____ ▶ Signature _____

DEA# (required) _____ State License # _____

Practice /Clinic Name _____ Same Billing as Primary Location? ☐

Address _____

City_____ State _____ Zip _____

Phone _____ Fax _____

Office Contact if Other Than Physician _____ Phone _____

Office 3 Information

Prescriber Name _____ ▶ Signature _____

DEA# (required) _____ State License # _____

Practice /Clinic Name _____ Same Billing as Primary Location? ☐

Address _____

City_____ State _____ Zip _____

Phone _____ Fax _____

Office Contact if Other Than Physician _____ Phone _____

Office 4 Information

Prescriber Name _____ ▶ Signature _____

DEA# (required) _____ State License # _____

Practice /Clinic Name _____ Same Billing as Primary Location? ☐

Address _____

City_____ State _____ Zip _____

Phone _____ Fax _____

Office Contact if Other Than Physician _____ Phone _____