Integration Solutions
Partnerships Make It Possible

ChildNet
Medical Associates

New Account Form

Multi-Site Practice ☐ Yes ☐ No Workers Comp Provider ☐ Yes ☐ No 340B Provider ☐ Yes ☐ No

DSI Agent: Integration Solutions, LLC

Please Include: □ Copy of Physicians License □ DEA License □ Initial Drug Order or Formulary (Including monthly CII request –if any)

New accounts will not be processed without the following information completed in its entirety.

PRACTICE INFORMATION

Practice Name: _____

Practice Specialty: _____

Practice Tax ID#: _____

Trade Name (DBA): _____

NPI #: _____

BUSINESS INFORMATION

Organization of Business (Check One)
□ Corporation □ LLC □ Partnership □ Sole Proprietor □ Other

State of Incorporation: _____ Date Established: ___/___/____

Bill to: □ Shipping Address □ Billing Address □ Other

Billing Method: □ Net/30 Terms □ Credit Card □ Other: _____

Practice Contact/Decision Maker: _____ Email: _____

Contact Responsible For Ordering: _____ Email: _____

Billing/Accts. Payable Contact: _____ Email: _____

Shipping Address: _____ Phone: _____

_____ Fax: _____

Billing Address: _____ Phone: _____

_____ Fax: _____

DEA SCHEDULED CONTROL REQUIREMENTS

☐ Controlled Drugs ☐ N/A

(***If you would like to order controlled drugs, please complete the information on Page 3. The address printed on the DEA license must match your shipping address EXACTLY, without exception)***

Name on DEA License: _____ DEA License No.: _____ Expiration Date: _____/_____/_____

Approved Schedules as indicated within DEA License: ☐2 ☐2N ☐3 ☐3N ☐4 ☐5

STATE LICENSE INFORMATION

(A copy of your State Medical License must be attached, without exception)

Name on License: _____ State Medical License No.: _____ Expiration date: ____/_____/_____

Please read carefully and sign below:

The undersigned herby certifies that this location dispenses medications within the rules and regulations of the governing state and the Federal DEA and does the appropriate due diligence assuring a physician/patient relationship exists and that the prescriptions issued are for a legitimate medical purpose within the scope of the physician's professional practice. Products purchased are intended for "own use" only in the provision of healthcare services in the location as referenced above, further, products shall not be distributed or sold to anyone for the purpose of resale to any third parties. The undersigned also herby certifies that it does not engage in "Internet Pharmacy" activity, and is not affiliated with or participate in any "Internet Pharmacy activities. The undersigned further agrees to assume complete responsibility of medication delivery to his/her own patients, and will take reasonable and responsible care in the delivery of such medications. DSI and its associates, affiliates, and authorized agents are not responsible for improper dispensing/delivery of medications, and assume no liability for such action. The undersigned states that the information provided is true and correct to the best of his/her knowledge. Furthermore, the above named practice agrees to all of DSI's conditions of sale. In the event that this account is referred for collection either in-house or to an outside agency, the above named practice agrees to pay all collection costs and fees. In the event it is deemed necessary by DSI to proceed with litigation, all collection costs and attorney fees will be paid to the prevailing party.

Signature: **X** _____ Title: _____ Date: _____

(Responsible Party)

OPTIONAL SERVICES & EQUIPMENT

DISPENSING SOFTWARE ☐ **Yes** ☐ **No**

(If your practice includes multiple sites, please designate a Facility Administrator who will oversee all sites and grant access to each individual site's Facility Administrator).

☐ Master Administrator: Title: Email:
☐ Facility Administrator: Title: Email:

Provider Information:

- **Please fill out the form below with all providers, in addition to your primary physician, who will be dispensing from your site. This section must be completed if your practice would like to order controlled substances.**

First Name	Last Name	Degree	DEA License	DEA License Exp. Date	State Medical License	State Medical License Exp. Date	NPI#

DISPENSING ACCESSORIES

Description	Cost	Order	Extended
□ Dispensing Cabinet:	$300	_____	_____
□ Bar Code Scanner	$300	_____	_____
□ Printer Credit	$150	_____	_____
□ Rx for Success	$79	_____	_____
□ Pharmacy Labels	$15/per 300	_____	_____
□ Pharmacy Bags	$16/per 500	_____	_____

340B INFORMATION ***(If applicable, a current, legible copy of your pharmacy license must be attached, without exception)*** ☐ N/A

State Board of Pharmacy License Type: ☐ Full Pharmacy ☐ Dispensary

HRSA 340B ID# Prime Vendor Program Participant ☐ Yes ☐ No

Signature: **X** _____Title: _____Date:_____
(Responsible Party)

Controlled Drug Survey *(Needed only if ordering controlled substances from DSI)*

*Practice Name:*_____

I intend to order controlled substances from DSI for the purpose of in-office dispensing: ☐ Yes ☐ No
(If yes, fill out all questions listed below)

Please list requested item number(s) (or description) and monthly quantity: _____

_____

1. Hours of Operation: From _____ To _____

2. Average number of providers per day at location(s): _____

3. Average number of patient visits to the practice per day: _____ Average number of patients per day / per provider _____

4. Average # of Rx's ***dispensed*** per day _____

   % of Controlled Substances ***dispensed***_____ % Non-Controlled Legend ***dispensed*** _____

   Which Scheduled Controlled Substances are dispensed? **II __ III __ IV __ V __**

If the percent of patients receiving controlled substances is greater than 50% please explain:

_____

5. Average # of Rx's ***written*** per day (If applicable) _____

   % of Controlled Substances ***written*** _____ % Non-Controlled Legend ***written*** _____

6. Please list the types of non-controlled (Legend) drugs that are either ***written*** or ***dispensed***. (Examples: Amitriptyline, Diclofenac, Etodolac, Nortriptyline, Meloxicam, Naproxen, Orphenadrine, Tizanidine)

_____

_____

7.

Do you have adequate storage and security to handle controlled substances?	___ Y	___ N
Is access to controlled substances restricted to authorized individuals only?	___ Y	___ N
Have you experienced any theft or loss of controlled substances?	___ Y	___ N
Are employees screened and drug tested?	___ Y	___ N
Do you dispense via mail order?	___ Y	___ N
Does your practice dispense over the internet?	___ Y	___ N
Do you dispense ***only*** after having a "face-to-face" visit with a patient?	___ Y	___ N
Do you accept patient insurance coverage?	___ Y	___ N
Do you engage in out of state dispensing or prescribing?	___ Y	___ N
Does your state have a controlled substance monitoring system?	___ Y	___ N

8. Has the practice or any employee of the practice ever had a state/federal license or DEA license suspended, denied, revoked, restricted or disciplined due to the improper dispensing or prescribing of controlled substances? If yes, please describe in detail (attach copy of supporting documentation): _____

Signature: _____ Title: _____ Date: _____
(Responsible Party)