# New Customer Account Application

NABP Accredited Drug Distributor

| | | |
|---|---|---|
| Facility Name: | | |
| Entity Type: ☐ Hospital ☐ Clinic ☐ Physician's Office ☐ Pharmacy ☐ Midwife | | |
| Shipping Address: | | |
| Shipping Address 2: | | |
| City: | State: | Zip Code: |
| Bill to Address: | | |
| City: | State: | Zip Code: |
| Purchasing Contact: | Phone: | E-mail: |
| AP Contact: | Phone: | E-mail: |
| Direct Contact for Invoices & Statements: | | E-mail: |
| Are you a member of a Group Purchasing Program/s? ☐ Yes ☐ No | | |
| If yes, what is your primary GPO? | | |
| GPO Membership ID #: | GLN Number: | |
| HIN #: | Tax ID #: | |

*Please note: Customer will be responsible for notifying HPSRx of any changes in their GPO status*

*I declare under penalty of perjury that the foregoing information is true and correct.*

Signature (Required) Date

Please Print Name Title

Phone: 800-850-1657 • 1640 Roanoke Blvd, Salem, VA 24153 • Fax: 800-361-6984 • customerservice@hpsrx.com

## License Agreement

A current and valid copy of your State License, issued by the state in which the facility is located, must be submitted with the application to establish an account.This form serves to document that the facility operates under the licensed supervision of the healthcare provider listed below, in accordance with applicable state law. If utilizing a state pharmacy license, the address on the license must match the shipping address provided on page 1. If utilizing a physicians license, a completed and signed letter of authorization must be provided.

**Accepted State Licenses:**

- Physician
- Nurse Practitioner
- Midwife*
- Nurse Midwife
- Pharmacy

*If you are a midwife in a state requiring standing orders, please submit with license

**License Holder:** Please ensure that a copy of the license is provided when submitting this application

| | | |
|---|---|---|
| Name of Person on License: | Name of Entity: | |
| License Number: | Expiration Date: | License Type: |
| Street Address 1: | | |
| Street Address 2: | City: | State: Zip Code: |

## Additional Ship to Sites:

If the provider license listed above is associated with additional locations, please provide the other locations you would like to have set up in our system.

| | | |
|---|---|---|
| Entity Name: | Contact Name: | |
| Ship to Street Address: | | |
| City: | State: | Zip Code: |
| Phone: | E-Mail: | |
| Entity Name: | Contact Name: | |
| Ship to Street Address: | | |
| City: | State: | Zip Code: |
| Phone: | E-Mail: | |

## Additional Ship to Sites Continued

| | | |
|---|---|---|
| Entity Name: | Contact Name: | |
| Ship to Street Address: | | |
| City: | State: | Zip Code: |
| Phone: | E-Mail: | |
| Entity Name: | Contact Name: | |
| Ship to Street Address: | | |
| City: | State: | Zip Code: |
| Phone: | E-Mail: | |
| Entity Name: | Contact Name: | |
| Ship to Street Address: | | |
| City: | State: | Zip Code: |
| Phone: | E-Mail: | |

If multiple addresses have been provided under the same physicians license, the following agreement must be completed by the physician whose license is being utilized.

*I, (name)_____, am the responsible person for purchases made by (facility) _____ under my state license number _____issued by the state of _____. I will notify HPSRx Enterprises immediately if my responsibility status and/or relationship with this facility is changed or terminated.*

*Physician Signature:*_____

# Credit Application

*Please complete either the credit application or the credit card application.

**Credit Information:**

| | |
|---|---|
| Primary Supplier: | Phone: |
| Secondary Supplier: | Phone: |
| Trade Reference: | Phone: |
| Credit Amount Requested: | Estimated Annual Dollar Volume: $ |

**Bank Information:**

| | | |
|---|---|---|
| Bank Name: | Bank Contact: | |
| Account Number: | Address: | |
| City: | State: | Zip Code: |

**Invoices and Statements:**

How would you like to receive invoices and statements? ☐ E-mail ☐ Fax _____ ☐ Mail _____

***In Submitting this application, the undersigned hereby warrants the following:*** *The information submitted is true and correct. HPSRx Enterprises Inc. is authorized to investigate the applicants' credit and/or and credit-reporting agency. In consideration of the extension of credit, the undersigned agrees that payment in full will be made no later than thirty (30) days from the invoice date. A 1.5% per month finance charge will be assessed on all past due balances. Applicant agrees to pay any collection cost incurred to collect the balance amount, including reasonable attorney's fees, if necessary. By submitting this application, you grant HPSRx Enterprises Inc. permission to inquire about the banking, business, and trade references you have listed. Payment options are by check or credit card. We accept Visa, MasterCard, American Express and Discover.*

_____

Signature of Responsible Party Date

_____

Please Print Name Title

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HPSRX ENTERPRISES

## Credit Card Application

*Please complete either the credit application or the credit card application.

| | | |
|---|---|---|
| Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover | | |
| Credit Card Number: | Security Code: | |
| Cardholder's Name as it appears on Card: | | Expiration Date: |
| Billing Address: | | |
| City: | State: | Zip Code: |

*By signing below, I authorize HPSRx Enterprises Inc. to automatically charge the credit card listed above each time an order is placed.*

Signature of Card Holder Date

Please Print Name Title

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# Terms and Conditions

## Price Policy

We make every effort to maintain our prices, but we reserve the right to make price adjustments in response to manufacturers' price Increases or extraordinary circumstances. Prices and terms are subject to change without notice.

HPSRx Enterprises Inc and Customer agree that the terms and conditions here in after set forth shall govern the relationship between HPSRx Enterprises Inc and Customer. Customer acknowledges and accepts all such terms and conditions by placing an order for goods with HPSRx Enterprises

## Payment Policy

HPSRx Enterprises Inc. is authorized to investigate the applicants' credit and /or any credit reporting agency.
In consideration of the extension of credit, the undersigned agrees that payment in full will be made no later than thirty (30) days from the invoice date. A 1.5% per month finance charge will be assessed on all past due balances after 45 days past due account will be place on hold and orders will not be filled until payment In full has been received.
Applicant agrees to pay any collection costs incurred to collect the balance amount, including reasonable attorney's fees, if necessary. Payment must be made In US currency only and may be In the form of a check or credit card.
Customer agrees not to make any deductions from payment unless a credit memo has been issued or authorization from accounts receivable representative. Credit memo number must be documented on check or invoice.

## Shipping Policy

Continental US: Free FedEx ground shipping on pharmaceutical orders totaling $250.00 or greater, shipping within the contiguous US. Pharmaceutical orders under $250.00 and other product orders are subject to actual shipping charges. Account is responsible for return shipping charges unless deemed an HPSRx error.

There will be a Refrigeration Handling fee of $10.00 added to any refrigerated order shipped. All refrigerated items are shipped Monday through Thursday via FedEx Priority Overnight. We will not ship refrigerated products on Fridays or the day before a holiday.

Early AM delivery, next business day, 2nd day shipping services, or Saturday delivery are available for an additional fee. Refrigerated items ordered with non-refrigerated items may be shipped separately.
Regulations require that we sell & ship controlled items to registered, licensed facilities only (no P.O. Boxes or residential addresses). We must have a valid copy of your DEA license, verifying shipping address, on file.

Alaska & Hawaii: All orders are subject to a shipping fee.

HPSRx Enterprises Inc. is not responsible for delays in transit due to weather conditions, carrier strikes, and other acts for nature which may impede shipment for product.

## Return Policy

HPSRx Enterprises Inc cannot accept any returns without prior authorization. To arrange for a return please call our Customer Service department. The following conditions must be completed. All returns must be unopened and properly labeled. Authorization and acceptance of returns for reasons other than a shipping error or damage, as long as the product is resalable, is at the sole discretion of HPSRx Enterprises.

- All returns must be accompanied by a copy of return authorization.
- Returned products must have been purchased within the previous 30 days. Any returns past 30 days are subject to a restocking fee.
- Any shortages or errors in shipments must be reported within 7 days of invoice date to issue credit (if applicable).
- Return labels will not be provided unless deemed an HPSRx error.
- **Non Returnable Items:** Expired Products, Controlled Drugs, Immune globulin Products, Items that cannot be returned to the manufacture, and Special order items

Federal law requires that any drugs returned to a wholesale distributor, are kept under proper conditions for storage, handling and shipping. The Prescription Drug Marketing Act also requires that written documentation indicating that proper conditions were maintained is provided to the wholesale distributor to which the drugs are returned. HPSRx Enterprises has a form which will need to be completed and returned to document this information. Upon approval of return, authorization must faxed back to the representative authorizing return.

*Please continue to the next page of the application before submitting

# Terms and Conditions Continued

*By signing below, you confirm that the information provided is accurate and that you have the authority to act on behalf of your state and company. Your signature also indicates that you have reviewed and understood our license agreement, terms and conditions, and banking policy, and that you agree to comply with all of them.*

**Please check and confirm that you have read and completed either the Credit Agreement OR the Credit Card Agreement*

| | |
|---|---|
| ☐ License Agreement | ☐ Terms and Conditions |
| ☐ Credit Agreement (If applicable) | ☐ Credit Card Agreement (If applicable) |

Please return completed application to customerservice@hpsrx.com or by faxing it to 800-361-6984

Signature (Required) Date

Please Print Name Title

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