Hybrid Pharma

1015 W. Newport Center Drive #106-A

Deerfield Beach, FL 33442

Ph: 954.708.2771

Fax: 954.708.2993

www.hybridpharma.com

New Account Set Up Forms

Business Name:	*Address:*
Doctor's Name:	
Doctor's Medical License*: *Please attach the copy of the licenses.	
Doctor's DEA*: *Please attach the copy of the licenses.	
Doctor's Signature:	
Office Manager's Name:	
Office Phone:	
Office Fax:	
Website Address:	
Include Invoice in Shipping?	☐ *Yes* ☐ *No* If you choose No, we will send by email to email address specified below.
Contact person email:	

HYBRID PHARMA *1015, W. Newport Center Drive, # 106A*

Deerfield Beach, Fl 33442 *Ph: 954 708 2771* *Fax: 954 708 2993*

Physician Statement

Pharmacies are legally bound to fill prescriptions written by physicians who maintain a valid patient - physician relationship with their patients. Practitioners, pursuant to state and Federal law, should prescribe within their scope of practice. Along with this form, please provide a copy of the Physicians State license and the DEA license you may have. Pursuant to the State and Federal Law, Hybrid Pharma requires the prescribing physicians agree the some elements of legitimate doctor/patient relationships. They include, but not limited to patient(s) have legitimate medical complaint, *face-to-face* physical as well as medical history examination.
We also request you to furnish the following information about your patient(s).

*Prescriptions must contain the patient's name, date of birth, address, and phone number.

*All prescription must have complete instructions to use.

*This "Physician Statement" regarding all the patient-physician relationships must be on file at Hybrid Pharma office prior to the dispensing of any prescriptions.

* Any logical connection exists between any medical complaint, the medical history, the physical examination, and the drug prescribed.

I, (Print Name)----------, certify that all prescriptions to Hybrid Pharma., will meet all the criteria above, I agree that there is no other agreement written, oral or otherwise that negates this one.

Physician Signature: ---------- **Date----------**

Please fax this completed form and the copies of Physician State license to Hybrid Pharma Fax: 954 708 2993

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This document confirms your request for payment by credit card, debit card, and/or by check. By submitting this form, you agree to pay any and all amounts charged by Hybrid Pharma [for any purchases made] to your credit card account specified below, and authorize Hybrid Pharma to obtain credit approval from said credit card company.

Account Authorization Form

- I hereby authorize Hybrid Pharma to charge my credit card account below. I affirm that I am at least 18 years old and that I am legally authorized to use the credit card account number specified below.
- Furthermore, I understand and agree that any charges made to the account specified below are non refundable, and agree to pay pursuant to my agreement with said credit card company, and any such amounts charged by me both in the past and henceforth.
- Additionally, I agree to hold Hybrid Pharma 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 shown below.

Personal Information

Name:
Billing Address
City/State/Zip
Phone Number_____Email:_____

Card: VISA---------- MASTER CARD----------AMERICAN EXPRESS----------
CARD NUMBER _____
EXPIRATION _____ CVV CODE _____
SIGNATURE_____ EFFECTIVE DATE_____

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Physician's Confirmation of Office Use Only Agreement

Pursuant to Florida Administrative Rule 64B16-27-.700, F.A.C. Definition of Compounding "Office use" means the provision and administration of a compounded drug to a patient by a practitioner in the practitioner's office or by the practitioner in a health care facility or treatment setting, including a hospital, ambulatory surgical center, or pharmacy. A pharmacist may dispense and deliver a quantity of a compounded drug to a practitioner for office use by the practitioner in accordance with this section provided:

(a) The quantity of compounded drug does not exceed the amount a practitioner anticipates may be used in the practitioner's office before the expiration date of the drug;
(b) The quantity of compounded drug is reasonable considering the intended use of the compounded drug and the nature of the practitioner's practice;
(c) The quantity of compounded drug for any practitioner and all practitioners as a whole, is not greater than an amount the pharmacy is capable of compounding in compliance with pharmaceutical standards for identity, strength, quality, and purity of the compounded drug that are consistent with United States Pharmacopoeia guidelines and accreditation practices.
(d) The pharmacy and the practitioner enter into a written agreement. The agreement shall specifically provide:
1. That the compounded drug may only be administered to the patient and may not be dispensed to the patient or sold to any other person or entity;
2. That the practitioner shall include on the patient's chart, medication order, or medication administration record the lot number and the beyond-use-date of any compounded drug administered to the patient that was provided by the pharmacy;
3. That the practitioner will provide notification to the patient for the reporting of any adverse reaction or complaint in order to facilitate any recall of batches of compounded drugs.

I understand and certify that all the prescriptions sent to Hybrid Pharma for "Office Use" will meet all the criteria above. I also understand that there is no other agreement oral or written that negates this one.

Physician Name:
(One agreement per Physician)
Physician Signature: **Date:**

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Damaged and Missing Goods Return policy

- *All our shipments will leave the facility after strict quality control. In the event of an unfortunate incident(example: damaged, missing or shorted item) the following procedure need to be followed.*
- *as soon as you receive your items inspect the contents of your packages to make sure it is complete.*
- *any and all the missing and/or damaged items need to be reported to us within 24 hours, no exceptions. No exchanges or refunds will be honored unless we are notified within 24 hours, no exceptions.*
- *you are requested to keep all the damaged products and packaging in the condition as it was delivered as it need to be returned to delivery service inspections.*
- *lost packages are generally located by the carrier and delivered. Replacement will be sent only after the lost claim is processed.*

We will pay return shipping fees in case of defective products, damaged items and wrong shipments.

I agree to the above policy:

Office Manager Name or Practitioner Name:_____

Signature: _____ ***Date***:_____