



# New Account Information & Credit Application

3607 Old Conejo Road, Thousand Oaks, CA 91320  
Toll Free (800) 333-9800 Fax: (800) 333-9916

Sales Rep: \_\_\_\_\_

**BILL TO:**

Bus Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Contact: \_\_\_\_\_

Email: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Yrs. In Bus: \_\_\_\_\_ Tin: \_\_\_\_\_

Hours of Operation:

S \_\_\_\_\_ - \_\_\_\_\_ M \_\_\_\_\_ - \_\_\_\_\_ T \_\_\_\_\_ - \_\_\_\_\_ W \_\_\_\_\_ - \_\_\_\_\_ T \_\_\_\_\_ - \_\_\_\_\_ F \_\_\_\_\_ - \_\_\_\_\_ S \_\_\_\_\_ - \_\_\_\_\_

**SHIP TO:**

Bus Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Contact: \_\_\_\_\_

**Organization of Business (Check One):**

Sole Proprietor

Limited Liability

Partnership

Corporation

**Please Select One Type of Account**

**Credit Card (no terms – no extra charge)**

Please Complete CC Auth Form (Page #4)

**Terms Net 30**

**Auto Debit -1% Discount**

**Company Officers/Owners**

Name: \_\_\_\_\_ Position: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Banking Information**

Institution Name/Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Contact: \_\_\_\_\_ Acct. #: \_\_\_\_\_

For Auto Debit Accounts only - ABA #: \_\_\_\_\_

**Trade References**

Name: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Acct. #: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_



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### All New Accounts Are Required To Send A Current Copy Of their Medical and DEA License.

**Prescription/Controlled Product Authorization:** I, \_\_\_\_\_ (Licensed Medical Professional) authorize the following personnel to purchase/receive prescription drug products and needles/syringes on my behalf: \_\_\_\_\_

I understand that it is my responsibility and the responsibility of my practice to adhere to any state and/or federal laws regarding prescription drug labeling.

**Initial here:** \_\_\_\_\_

This practice does not market or distribute medication via the internet.

**Initial here:** \_\_\_\_\_

It is my responsibility and the responsibility of this establishment to comply with all State and Federal rules related to the storage and dispensing of pharmaceuticals.

**Initial here:** \_\_\_\_\_

**Practitioner Signature:** \_\_\_\_\_ **DEA#:** \_\_\_\_\_ (must match shipping address)

**Limit purchases to only non-controlled products**

**Shipping Terms & Conditions:** Order minimum for prepaid express freight is \$250.00. All orders under \$250.00 will have a standard charge of \$10.00 per invoice to cover freight and handling. The carrier will be UPS or Fed-Ex. If same or next day delivery is requested, the actual freight charges for this service will be added to the invoice. On all injectables that require refrigeration & next day services, the actual freight charges will be added to the invoice.

**Payment Terms:** An invoice will accompany each order shipped. The net invoice amount is due based upon your agreed upon terms. Payments not received in accordance with our policy shall bear interest after 31 days from the invoice date at the rate of 1.5% per month until paid. Physician Partner will send you an account statement once a month.

**Damaged Shipments:** Contact Physician Partner immediately at 1-800-333-9800. Please keep the original shipping box with packing materials and product for inspection. Physician Partner will arrange for this inspection to claim for damages and proper credit. If items are missing from your order, recheck the contents against the enclosed invoice. If a shortage has actually occurred, you must call Physician Partner within 24 hours in order to receive proper credit. The DEA will be notified on all control products that have to be reported damaged or missing.



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**Returned-Goods Policy:** All returns must be authorized by our customer service department in advance to receive proper credit. Any package shipped to Physician Partner without prior authorization will be refused upon arrival. To obtain a return authorization number, call the customer service department at 1-800-333-9800. Physician Partner reserves the right to refuse credit on any merchandise due to damages, special orders, excessive purchases, or unusual requests. Physician Partner will accept returns for established accounts based upon the following: (please note all computations will be made from the date of the invoice): 0-15 days=no charge, 16-30 days=25% restocking fee, after 30 days=no returns are accepted.

**Jurisdiction and Choice of Law:** This agreement shall be construed and interpreted in accordance with the laws of the State of California without regard to conflict of laws, and the courts of California. California shall have exclusive jurisdiction in any controversy relating to or arising out of this agreement.

**Signature and Guaranty:** "I, the undersigned, so hereby state that the above information and any information in any documents attached hereto is true and correct to the best of my knowledge. I understand that you will retain this application whether or not it is approved. I realize that you expect to investigate my credit. I authorize you to obtain (if you desire) a credit report from any credit reporting agency, including (among others) a consumer reporting agency. I further authorize any bank with whom I (or where appropriate, the corporation) am doing business to give all necessary information to you which will assist in your credit investigation, and release any claim I (and where appropriate, the corporation or limited liability company) may have for breach of contract or invasion of privacy because of information furnished to you. I understand and agree that this new account information form, when accepted by Physician Partner, constitutes a binding agreement between the two parties hereto, and the terms of sale set forth above hereby constitute a part of this agreement. Also, I agree to pay the collection costs and reasonable attorney's fees incurred upon default of any of the charges due and consent that such costs and fees shall be made part of any judgment rendered thereon."

**If this account is for a corporation or limited liability company, the undersigned(s) personally guarantee payment of all debt to Physician Partner.**

**My signature below is as an officer of the corporation or member of a limited liability company and as a personal guarantor of any and all indebtedness of the account holder to Physician Partner incurred hereunder.**

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Title: \_\_\_\_\_



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### CREDIT CARD AUTHORIZATION AGREEMENT

I, \_\_\_\_\_, the holder of (check one, please):

VISA\_\_ MasterCard\_\_ American Express\_\_ Discover\_\_

Card Number: \_\_\_\_\_, Expiration Date \_\_\_\_/\_\_\_\_, and Pin Number \_\_\_\_\_ (3 digits for Visa and MasterCard; located on the back of the card or 4 digits for American Express; located on the front of the card), hereby authorize Physician Partner to charge my credit card upon purchase of goods.

Cardholder Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Fax this completed form to: (800) 333-9916**