CARIE BOYD'S
PRESCRIPTION SHOP

NOTICE: *To avoid any delay with your orders, please submit a physical copy of your state and DEA license(s) with this enrollment form.*

Prescriber Enrollment Form

Prescriber Information			
First Name:	MI:	Last Name:	NPI:
DEA:	Prescriber State License(s)*:	Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ _____	
Practice Name:			
Practice Address:			
City:	State:	Zip:	Phone:
Fax:	Email:		

Office Contact	
Name:	Email:
Position in prescriber's office:	**Office Contact Signature:**

Credit Card Information			
As the cardholder, by signing below I hereby authorize Carie Boyd's Prescription Shop to use the card listed below to process payment for any and all of the orders made by the prescriber listed above.			
Name as it appears on the card:			
Type of Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS			
Credit Card Number:	Expiration Date:	Security Code:	
Credit Card Billing Address:			
City:	State:	Zip:	Cardholder Phone:

Cardholder Signature:	**Date:**

Prescriber & Outsourcing Facility Agreement

By signing this enrollment form, the prescriber listed above acknowledges and agrees that:

- He/She has the requisite licensing and other certifications necessary to order compounded products from Carie Boyd's Prescription Shop (the "Outsourcing Facility") in accordance with all applicable laws;
- All of the compounded products he/she may purchase from the Outsourcing Facility are clinically different from those that are commercially available;
- When he/she purchases compounded products from the Outsourcing Facility, he/she will have made a determination that those products, rather than any commercially available products, are necessary for his/her patient(s) based on his/her clinical judgment as a medical professional;
- He/She will advise patients to contact him/her directly in the event that they experience any adverse reaction to any of the Outsourcing Facility's compounded products;
- He/She will immediately advise the Outsourcing Facility in the event that any patient experiences any adverse reaction to any of the Outsourcing Facility's compounded products; and
- With respect to any patient that receives or is prescribed any of the Outsourcing Facility's compounded products, he/she will include on each of those patients' charts, medication orders, or medication administration records the lot numbers and expiration dates of the compounded products.
- An electronic, photocopied, or other copy of a signature will be a valid signature for all purposes and may be submitted to the Outsourcing Facility by electronic mail or other similar transition methods.
- If all invoices are not paid when due, he/she will accrue late charges at the rate of 18% per annum or the maximum rate permitted under applicable law, whichever is less. If it is necessary to take legal action, the jurisdiction shall be the State of Texas and the venue shall be Tarrant County, Texas. The prescriber listed above agrees to reimburse the Outsourcing Facility for any attorney fees, court costs, or other costs of collection which may be incurred in its efforts to collect any past due debts.

Prescriber Signature:	**Date:**

Please fax or email a signed copy of this form (800) 883-4791 or email to orders@carieboyd.com

800-930-4361 800-883-4791 CarieBoyd.com orders@carieboyd.com