



A Custom Compounding Pharmacy
Where Your Health Matters

972-517-7900 972-517-0400

www.springcreekpharmacy.com

rx@springcreekpharmacy.com

Account Name: _____

ONBOARDING FORM

Representative: _____

Primary Prescriber: _____

State License Number: _____ NPI: _____

Supervising Physician/Medical Director: _____ NPI: _____

Phone: _____ Fax: _____ Email: _____

Physical Address: _____ City: _____

State: _____ Zip: _____ ☐ Check box if billing address is same as physical

Billing Address (if different from physical)

City: _____ State: _____ Zip: _____

Credit Card #:

Exp Date:

Security Code:

Name on card and billing address if different from physical address:

Please note all payments for prescriptions are processed as the medication goes out. We will need to keep a credit card on file for these payments. Please indicate below how you would like to receive the statements.

• Fax receipts to: _____ • Email receipts to: _____

PLEASE PROVIDE A LIST OF ALL PRESCRIBERS THAT WILL BE SENDING PRESCRIPTIONS UNDER THIS CLINIC, ALONG WITH THE CORRESPONDING NPI NUMBERS

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