Verifications Department
Phone: 800-331-1984

Date: _____ Account: _____

Controlled Substance Form (Urgent Response Required)
MUST COMPLETE ALL FIELDS ON THE FORM

Office Address: _____

_____

Office Phone #: _____

Office Fax #: _____

E-mail Address: _____

HF Acquisition Co., LLC is required as a distributor of controlled substances and list one chemicals to "Know Our Customer," based on Federal DEA regulations. The information you provide will assist us in our regular and ongoing review process and help expedite the processing of your current and future controlled substance orders.

1. Please circle your practice type: "Large Group", "Solo practice", "Other" (Please Explain) _____
   _____
2. Website (if any) _____
3. List your Board Certification: _____
4. Current practice specialty: _____
5. Is the practice owned by a licensed practitioner? Yes ☐ / No ☐ (If no please provide owners name and occupation) _____
   a) Is the above listed address your: Home ☐ / Office ☐ / Both ☐
   b) If Home Office, is there a separate entrance to your practice? _____
   c) Is there a separate practice address? _____
6. Number of Practitioners in this office:
   Doctors _____ PAs _____ NPs _____ Other (List) _____
7. Do you have an onsite Pharmacy/Dispensary? Yes ☐ / No ☐
   If Yes, is it open to the public? Yes ☐ / No ☐
8. Do you accept insurance? Yes ☐ / No ☐ , **% of patients without insurance (self-pay)* _____%*
9. Do you have controls to ensure only authorized employees are able to order and receive controlled substances? Yes ☐ / No ☐
   Registrant Only _____ Second level approval _____
10. Days /Hours of operation: _____
11. Approximately, how many patients are seen in the office daily? _____
    What percentage of patients are from out of state _____%

12a. Please circle the approximate % of patients that leave your office with controlled substances daily (excluding prescriptions)?
0%, 1-10%, 10-20%, 20-30%, 30-40%, 40-50%, 50-60%, 60-70%, 70- 80%, 80-90%, 90-100

12b. Please circle the approximate % of patients that are treated in the office with controlled substances daily (excluding prescriptions)?
0%, 1-10%, 10-20%, 20-30%, 30-40%, 40-50%, 50-60%, 60-70%, 70- 80%, 80-90%, 90-100%

13. Are you registered with and inquiring/reporting to your State Prescription Drug Monitoring Program?
Yes ☐ / No ☐

11629 49th Pl W, Mukilteo, WA 98275 | T 425 771.5733 | F 425 775.2374 | 800.331.1984 | www.healthfirst.com
HFP 012 F-01 v006 Effective 1/30/2019

14. Do you use any controlled substances ordered from HF Acquisition Co LLC. to treat immediate family members? Yes ☐ / No ☐

    If yes, do you have a bona fide patient relationship with this family member including: maintenance of medical records, medical history and current condition, medical exam, and maintain records of controlled substance treatment? Yes ☐ / No ☐ If No, please explain: _____

    _____

15. Do you use any of the controlled drug items you order for your own personal use? Yes ☐ / No ☐
16. Please identify the number of suppliers you purchase controlled substances from? ☐ One / ☐ Two / ☐ Three

    If more than one controlled substance supplier;

    HF Acquisition Co LLC. is the: ☐ Primary / ☐ Secondary / or ☐ Tertiary supplier?

18. Does your office perform surgery, or any other in office procedures that require the use of controlled substances? Yes ☐ / No ☐
19. Please list all the controlled substances you intend to order from HF Acquisition Co LLC. For each controlled substance, please list the strength, expected quantity, expected frequency, and the conditions that the product(s) are being used to treat. This information will be used to expedite the shipment of your current and future controlled substance orders. To assist you in providing this information, we have attached a 24-month controlled substance history for the account's DEA license number, if available.

All Fields are required to be filled in to expedite the review of your Controlled Substance order.				
Product/Drug Name	**Strength**	**Expected Order Quantities**	**Expected Order Frequency (i.e. Monthly, Quarterly, etc.)**	**List the Conditions the Products are being used to Treat.**
Example- Midazolam	***Example-*** 2ml vial/1mg/ml	***Example-*** 1 Bottle 100 tablets	***Example-*** Monthly	***Example-*** Anxiety disorder
Example- Midazolam	***Example-*** 2ml vial/1mg/ml	***Example-*** 100 Vials	***Example-*** Monthly	***Example-*** Sedation

Do you maintain proper records relating to the ordering, storage, administration / dispensing and disposal of controlled substances as per Federal and State Requirements? Yes ☐ / No ☐

_____ _____

Individual completing questionnaire (print) Title

_____ _____

Signature Date

Under penalties of law, I hereby certify that I am the registrant whose name appears on the below mentioned DEA registration, or by power of attorney have been granted signing authority by the DEA registrant. I further certify that I am a party responsible for overseeing the use and handling of all controlled substance products purchased under this DEA registration. As evidenced by my signature below, I hereby certify the information in this form is true and accurate and I have fully reviewed this form prior to my signature.

_____ _____ _____

Registrant/POA Name (Print) DEA Number State License Number

_____ _____

Registrant/POA Signature Date

Return completed document to
Email: sales.operations@healthfirst.com
Fax: 425.775.2374