AnazaoHealth® Corporation | Create. Heal. Live.®

5710 Hoover Blvd.
Tampa, FL 33634

☎ 800.995.4363
800.985.4363

New Customer Set-Up Form

1. Complete New Customer Set-Up Form
2. Complete, sign and return Credit Application Terms & Conditions
3. The completed New Customer Set-Up Form can be faxed, mailed or emailed to:
   (The packet must be completed, signed and returned prior to first order being shipped)

AnazaoHealth Corporation
5710 Hoover Boulevard
Tampa, FL 33634-5339

Fax: 800.985.4363
(Attn: Customer Service)

E-mail: Customerservice@anazaohealth.com

As a new customer, you will automatically be enrolled in "**myAnazao**" for E-Commerce access which allows the physician or staff to place orders, add and edit patients, view status of orders, check on delivery status, run reports and view organization/physician/staff settings. If you wish to opt out of this enrollment, please check here. ☐

After processing the requested information, you will receive a welcome package within 3 – 7 business days.

AnazaoHealth Corporation is authorized to provide nationwide services including the District of Columbia and has successfully developed a national presence by providing its customers with high-quality, innovative solutions that simplify and/or improve patient care. We look forward to building a long-term relationship with your company and thank you for your business. Please contact our Customer Service Department if you have any questions or concerns at 800.995.4363, Option 5.

AnazaoHealth Corporate Office
5710 Hoover Blvd.
Tampa, FL 33634
Monday – Friday
8:30am – 7:00pm EST

AnazaoHealth Las Vegas Pharmacy
7465 W. Sunset Road, Ste.1200
Las Vegas, NV 89113
Monday – Friday
8:00am – 5:30pm PST

Phone: 800.995.4363

Option 1 – Pain
Option 2 – Nuclear
Option 3 – Custom
Option 4 – Brachytherapy
Option 5 – Customer Service
Option 6 – Accounting

Fax Orders
Nuclear – 800.697.5250
Pain – 800.985.4363

Fax Orders
Custom – 800.238.8239

NCSUF 02/09/15

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New Customer Set-Up Form

AnazaoHealth Corporation is HIPAA compliant. All information is kept strictly confidential.

Customer Information

Date_____

Name of Business/Practice_____
(No abbreviations)

Address_____

City, State, Zip_____

Phone_____ Fax_____

Contact person_____ Title_____

Email_____ Admin Email for myAnazao *(E-Commerce)*_____

Type of Organization: Corporation____Partnership___LLC___Other_____

Date business established_____ Estimated annual volume of business $_____

Billing Information *(If different from above)*

Billing Address_____

City, State, Zip_____

A/P Contact_____ A/P Email _____

A/P Phone_____ A/P Fax _____

Shipping Information *(Please use another sheet for multiple offices)*

Clinic/Hospital or Physician's office _____

Address _____

City, State, Zip_____

Contact_____ Dept._____

Phone_____ Ext_____ Fax_____

Special Shipping instructions_____

☐**Pain & Custom Accounts**

Physician Information *(Please use another sheet for additional physicians)*

Physician Name_____ DEA #_____

Physician Name_____ DEA #_____

Physician Name_____ DEA #_____

☐**Nuclear Accounts**

RAM License #_____

******** Note that all medications are compounded pursuant to the physician's prescription. *********

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Credit Application, Terms & Conditions

If account is Credit Card Pay only, please skip to Payment Method

Name of Business _____ Date _____

Federal Tax ID# _____ Duns # _____

Bank Reference: Bank Name _____ Bank Account _____

Bank Contact _____ Phone _____

Business References: (List 3)

1. Company Name _____ Account # _____

Address _____ Phone _____

City, State, Zip _____ Fax _____

2. Company Name _____ Account # _____

Address _____ Phone _____

City, State, Zip _____ Fax _____

3. Company Name _____ Account # _____

Address _____ Phone _____

City, State, Zip _____ Fax _____

Choice of Billing (Check all that apply)

☐ Monthly Summary
☐ Invoice per order Credit Limit Requested $_____
PO # required on original order? Yes☐ No☐
All customers will receive a month-end statement of open invoices

Payment Terms: All payments are **due 30 days** from date of invoice to: **AnazaoHealth Corporation, P. O. Box 850001, Orlando, FL 32885-0389**

Payment Method (Check one option below)

☐ Upon receipt of Invoice
☐ Credit Card (charged at time of order)
Your credit card is kept on file and a receipt will be sent stamped "paid."
☐ MasterCard ☐ Visa ☐ AMEX ☐ Discover

Credit Card # _____ Exp. Date _____

_____
Authorized Cardholder's Signature

The person(s) signing this Credit Application, Terms & Conditions form warrants that the above information is complete and accurate and hereby agrees to the following terms and conditions:

1. The undersigned agrees to immediately notify AnazaoHealth Corporation of any change in ownership, form or business name of the entity.
2. This document will be as effective in photocopy or fax form as in the original.
3. The undersigned acknowledges that AnazaoHealth Corporation may limit or discontinue credit at its sole discretion and that the continued extension of credit may require additional information from time to time.
4. The undersigned warrants that they have full authority to sign this agreement and obligate the entity hereunder.
5. The undersigned agrees that if all invoices are not paid when due, they will accrue late charges at the rate of 18% per annum or the maximum rate allowed by law, whichever is less. If it is necessary to take legal action, jurisdiction shall be the State of Florida and the venue shall be Hillsborough County, Florida. The undersigned agrees to reimburse AnazaoHealth Corporation for any attorney fees, court costs or other costs of collection which may be incurred in its efforts to collect any past due debts.

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

_____ _____
Printed Name/Title *Printed Name/Title*

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