SEVEN CELLS
Seven Cells Pharmacy 600 SE Indian St. Suite 3 Stuart, FL 34997
www.sevencellspharmacy.com
Phone: 561-467-4334
Fax: 866-308-5549
email: scripts@sevencells.com

ACCOUNT REGISTRATION FORM

EMAIL THIS FORM TO: SCRIPTS@SEVENCELLS.COM OR FAX TO: 866-308-5549

PROVIDER INFORMATION

Provider Name	:	Name of Facility	:
DEA Number/Exp. Date	:	Medical Lic. # / Exp. Date	:
NPI Number	:	Office Phone Number	:
Number of Physicians	:	Number of Locations	:
Fax Number	:	Cell Number:	:
Address	:		
City	:	State	:
Postal Code	:	Website	:
Primary Email	:	Primary Contact	:

BILLING INFORMATION

Cardholder Name	:					
Credit Type	:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX	☐ Other
Card Number	:					
Expiration Date (mm/yy)	:		CVV Code	:		
Billing Address	:					
City	:		State	:		
Postal Code	:					

PREFERRED DELIVERY LOCATION:

☐ PATIENT ADDRESS
☐ PRESCRIBER ADDRESS

I (we) hereby authorize Seven Cells Pharmacy to make recurring charges to the Credit Card listed above and, if necessary, initiate adjustments for any transactions credited/debited in error.
This authorization will remain in effect until I (we) cancel it in writing. I (we) agree to provide Seven Cells Pharmacy written, reasonable, accurate, and timely notification of any changes in my (our) account information, or termination of this authorization. Written notice may be provided either to the address above or via email to care@sevencells.com. I agree not to dispute these recurring charges with my bank/credit card so long as the transactions correspond to the terms indicated in this account registration form.

A receipt for each payment will be sent directly to the cardholder via email within 24 hours.

Signature

Date

SALES REPRESENTATIVE USE ONLY

NAME:	Jacob Morris
EMAIL:	jacob.morris@sevencellspharmacy.com