GENESIS COMPOUNDING
DBA SPECTRUM SOLUTIONS RX

FACILITY PROFILE

Completing this form helps us understand your possible medication needs and helps us to refer potential clients to you who inquire about practitioners in their area who provide requested services.

Facility Name _____

Address _____ City/State/Zip code_____

Phone_____ Fax_____ Website_____

Contact Name for Rx questions _____ Email_____

Contact for Office Billing questions_____Email_____

Practitioner Name(s):

NPI	NAME	DEA
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any workdays on which you close early, or are not open? This helps us avoid shipping meds to your clinic these days. _____

Please check all services you offer:

- ☐ **Aesthetic Services**
- ☐ **Anti-Aging**
- ☐ **Gut Health**
- ☐ **General Wellness**
- ☐ **Auto-Immune**
- ☐ **Thyroid Balance**
- ☐ **Men's Health**
- ☐ **Hair growth**
- ☐ **Skin care**
- ☐ **Women's Health**
- ☐ **Multi-Vitamin I.V. Infusions** *(Myers, Banana Bags, etc)*
- ☐ **Hormone Replacement Therapy**
  - ☐ Creams/Capsules ☐ Rapid-Dissolving Tabs ☐ Pellets ☐ Injectables
- ☐ **Weight Loss**
  - ☐ Oral Appetite Suppressants ☐ Vitamin Injections (M.I.C) ☐ OTC Vitamins
- ☐ **Sexual Health**
  - ☐ Oral Medications ☐ Nasal Atomized Medications

Other Services Provided _____

Please list items to be billed to facility account _____

Are there any products you currently use/require that we may be able to produce for you?

_____

Do you accept insurance for most services? ☐ Yes ☐ Yes, some services only ☐ No

Please fax completed forms to Genesis Pharmacy **Attn: Pharmacy Management (385) 855-1221**

Or email pharmacy@genesiscompounding.com