<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Specialty</th>
</tr>
</thead>
</table>

**PHYSICIAN’S INFORMATION**

<table>
<thead>
<tr>
<th>Physician’s Name</th>
<th>Physician’s Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical License Number</th>
<th>State</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

200

**OFFICE INFORMATION**

<table>
<thead>
<tr>
<th>Office Point of Contact (POC)</th>
<th>POC Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Address (Street, City, State, Zip)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Phone</th>
<th>Primary Fax</th>
<th>Back Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average Number of Scripts Per Week

**INCLUDE A COPY OF VALID DEA CERTIFICATE WITH THIS FORM**

Physician’s Signature (Please Keep Signature in Box)

1449 Whitehall Road, Annapolis, MD 21409
Phone: 1-800-943-7968  Fax: 410-650-4064  Email: Sales@RxNT.com
Practice Administrator Registration Form

RxNT’s Practice Administrator Site will allow Providers or designated Practice Administrators (Office Managers) to:

- Add/Remove/Edit staff members
- Reset Provider and staff passwords

The designated Practice Administrator (or Office Manager) below will receive login credentials and a training video with access to RxNT’s Practice Administrator site, which can be accessed at www.RxNT.com/PracticeAdmin

*Please note: Practice Admin is needed for Solo Practitioners too!

Practice Name: __________________________________________

Provider’s Signature: ______________________________________

Please identify the Practice Administrator (or Office Manager for the above practice):

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Practice Administrator Contact Phone Number: ______________________________________

Practice Administrator Contact Email Address: ____________________________________

The RxNT End User Service Agreement states that certain Services are intended for access and use solely by physicians and authorized members of their staff. If you are a physician, or a physician’s authorized representative, it is you sole responsibility to identify members of your staff who are permitted to access and use such Services, and to authorize, monitor, and control access to and use of such Services by your staff members. RxNT requires that all users have their own login and password.
Credit Card Payment Authorization Form

Sign and complete this form to authorize Networking Technology Inc dba RxNT to make a charge to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date and subsequent charges thereafter as checked below. Please note a 2.75% credit card processing fee will be charged to your card for license fees.

OR make checks payable to RxNT and Mail to 1449 Whitehall Road, Annapolis, MD 21409.

Please complete the information below:

I __________________________ authorize RxNT to charge my credit card account indicated below for yearly and/or monthly fees that incur.

The payment(s) are for (Please check all that applies):

- [ ] RxNT e-Prescriber
- [ ] RxNT Electronic Health Records
- [ ] RxNT Practice Management
- [ ] Direct Mail

- [ ] EPICS Token/yearly fee
- [ ] Annual Maintenance Fee: $25
- [ ] One-Time Token Activation Fee: $50
- [ ] Shipping Fee (Hard Token Only): $15

For the amount of: _______________________

Billing Address: __________________________ Phone#: _______________________

City, State, Zip: __________________________ Email: _______________________

Practice Name: __________________________ Specialty: _______________________

Account Type: [ ] Visa [ ] Mastercard [ ] Amex [ ] Discover

Cardholder Name: __________________________

Account Number: __________________________

Expiration Date: __________________________

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX): ___________

SIGNATURE: __________________________ Date: _______________________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

1449 Whitehall Road, Annapolis, MD 21409
Phone: 1-800-943-7968 Fax: 410-650-4064 Email: Sales@RxNT.com