HF Acquisition Co., LLC

Form Title: Know Your Customer Questionnaire Form

Document Number: HFP 012 F-01, Version 007, Effective Date 01/01/2024

KNOW YOUR CUSTOMER "KYC" FORM – URGENT RESPONSE REQUIRED
MUST COMPLETE ALL FIELDS AND SIGN

HF Acquisition Co., LLC is required as a distributor of controlled substances and list one (L1) 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 and/or L1 chemical orders.

Date: _____
Customer Account Number: _____
Ordering Doctor Name: _____
Office Address: _____
_____
Office Phone #: _____

1. Please circle your practice type: "Large Group", "Solo Practice", "Other" (Please Explain)
2. Is this practice owned by a licensed practitioner? Yes ☐ No ☐ (If no, please provide owners name and occupation) _____
3. Is the address listed above your: Home ☐ Office ☐ Both ☐
4. If a home office, is there a separate entrance to your practice? Yes ☐ No ☐
   a. If yes, please list the address: _____
5. Do you have an onsite pharmacy/dispensary? Yes ☐ No ☐
   a. If yes, it is open to the public? Yes ☐ No ☐
6. Number of practitioners in this office: Doctors_____ PAs_____NPs_____ Other_____
7. Do you have controls to ensure only authorized employees are able to order and receive controlled substances and/or L1 chemicals? Yes ☐ No ☐
8. Is only the doctor _____ or is there a second level approver _____ who is authorized to order and receive controlled substances and/or L1 chemicals?
9. Approximately, how many patients are seen in the office daily? _____
10. What percentage of patients are from out of state _____ %
11. _____% of patients without insurance/self-pay.
12. Approximate _____ % of patients that leave your office with controlled substances and/or L1 chemicals daily (excluding prescriptions)?
13. Approximate _____ % of patients that are treated in the office with controlled substances and/or L1 chemicals daily (excluding prescription)?
14. Are you registered with and inquiring/reporting to your State Prescription Drug Monitoring Program (PDMP)? Yes ☐ No ☐ If no, please explain why: _____
15. Do you use any of the controlled drug and/or L1 chemicals you order for your own personal use? Yes ☐ No ☐

16. Do you use any controlled substances and/or L1 chemicals ordered from HF Acquisition Co., LLC to treat immediate family member(s)? Yes ☐ No ☐
    a. 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? Yes ☐ No ☐ If no, please explain:
    _____
17. Please identify the number of suppliers you purchase controlled substances and/or L1 chemicals from?
    ☐ One ☐ Two ☐ Three or More
18. If more than one controlled substance supplier is HF Acquisition Co., LLC your: ☐ Primary ☐ Secondary or ☐ Tertiary supplier?
19. Does your office perform surgery, or any other in office procedures that require the use of controlled substances and/or L1 chemicals? Yes ☐ No ☐
20. 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 ☐
21. Please list all the controlled substances and/or L1 chemicals you intend to order from HF Acquisition Co LLC.

PLEASE BE SURE TO COMPLETE ALL FIELDS!				
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- Ephedrine	***Example-*** 50 mg/mL 1mL vial	***Example-*** 5 vials	***Example-*** Yearly	***Example-*** Sedation

_____ _____

Individual who completed 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.

_____ _____ _____

Doctor or POA Name (Print) DEA Number State License Number

_____ _____

Doctor or POA Signature Date

Return completed document to Verification's at:
Email: sales.operations@healthfirst.com
Phone: 1-800-331-1984 Fax: 425.775.2374