



Rcopia Provider Registration

By signing below the provider acknowledges that he/she: is a licensed practitioner with the legal authority to write prescriptions in the state(s) in which he/she practices medicine. I also hereby affirm that except as set forth in this paragraph, I will personally prescribe and order the medications using the user identifier ("user ID") and password provided to me by DrFirst. To the extent that someone other than myself uses the Rcopia system to order medications that I prescribe for patients who are under my care (for purposes of this agreement such person is referred to as the "Provider Agent") such person will be acting pursuant to my express written instructions and I agree that I am solely responsible for insuring that adequate documentation exists verifying that I am the prescribing physician and that such documentation will be provided to the Pharmacy dispensing such medication, and/or DrFirst, if requested.

Name of Practice: _____

Name of Provider: _____
(PLEASE PRINT or TYPE)

Provider Signature

Please provide your signature in the box below so that we can include it on your prescriptions when a signature is required. Please be sure to fill the entire box with your signature, but do not allow it to touch the sides.

Please email this form to **jhoff@simplifymd.com**.

Also include the following documents once completed:

- Copies of your DEA registration and state medical license
- Provider Agent authorization form

If you have any questions about the form or how to register your staff, please call (678) 578-6200 and ask for Jessie Hoff.