TransFigure Customer Account Profile

TransFigure
A UNITED BIOLOGICS WEIGHT LOSS PROGRAM

Revised Date: 09.10.25

All information requested on this document is required. Return this document to: jeff@vitalsync.info

Legal Practice Name: _____

(Business or Practice Name)

DBA: _____

Parent Account Name: _____

Form completed by: _____

Address	Street	City	State	Zip	Phone	Fax
Physical Address						
Billing Address (PO						

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Title	Last Name	First Name	Email (must be direct email for individual)	Direct Phone/Cell Phone
Owner of Practice				
CEO				
Office Manager				
Primary Contact				
Secondary Contact				
*Accounts Payable				

*Accounts Payable Contact = party responsible for payment of invoices

Participating Providers: Information below is required for all participating providers (MD, DO, PA, NP, etc.)

Last Name	First Name	Credentials	License Number	Individual NPI	Email