## HOW TO PURCHASE

**STEP 1:** Print and fill out the Order & Waiver forms below.

**STEP 2:** Fax completed forms and photo id along with your ORIGINAL PRESCRIPTION to **Toll Free Fax 1-800-807-0094**. If sending by mail, please send to:

**www.MedsForLess.com**
**#122, 1959 - 152 Street**
**White Rock, BC Canada V4A**
**9E3 Toll Free Ph: 1-866-600-5262**
**Email: info@medsforless.com**

**STEP 3:** You will be notified via telephone when we receive your order. Your prescription will be reviewed by a Canadian physician and verified with your doctor. Please allow 2 to 3 weeks from the day we confirm your order to final delivery to account for confirmation, verification, processing and shipping. NOTE: Canadian pharmacies cannot dispense medications without a valid prescription.

## ORDER FORM

**A) PATIENT INFORMATION** (Please print)

**First Name:** _____ **Last Name:** _____

**Address:** _____

**City:** _____ **State:** _____

**Country:** _____ **Zip:** _____

**Telephone:** _____ **Alternate Telephone:** _____

**Fax:** _____ **Email:** _____

**Birth date** (dd/mm/yy)**:** _____ **Gender:** _____

**Allergies:** _____

**B) Physician Information**

**Physician Name:** _____

**Physician Phone:** _____ **Physician Fax:** _____

**C) Payment Information (Visa or MasterCard #)**

**Credit Card #:** _____ **Expiry Date** (mm/yy) _____

**CONSENT & WAIVER OF LIABILITY**

I, _____, hereby authorize the pharmacy to apply applicable charges to my credit card for the cost of prescription drugs as noted above including refills on prescriptions submitted within 90 days. In addition, I also understand that a flat-rate shipping fee of $10.99 U.S. applies to each order. I also understand that a 90-day supply of the medication will be shipped unless otherwise specified. I also understand that a generic substitution will be filled when available unless otherwise specified. I ALSO UNDERSTAND THAT ALL QUOTED PRICES ARE SUBJECT TO FLUCTUATIONS IN THE EXCHANGE RATE.

Name of Credit Card Holder: _____

Signature: _____

**CONSENT FORM & WAIVER OF LIABILITY**

I (the patient), _____, of the city of _____ in the state of _____ have read, understand and agree to the following:

1. I am not seeking medical advice or treatment of any kind whatsoever in coming to Medicine Shoppe Pharmacy and its physicians, employees, officers, agents and all others acting through or for it. 2. Neither the pharmacy, nor any of its physicians, employees, officers agents and all others acting through or for it, or anyone that is acting on its behalf, is providing medical advice, professional advice, treatment advice or treatment of any kind whatsoever to me. 3. I am coming to Medicine Shoppe Pharmacy for the sole purpose of obtaining a prescription at a lower price than in the country of residence. I understand that no one on behalf of the Medicine Shoppe Pharmacy will take any steps whatsoever to determine whether the prescription is appropriate.

I, _____, hereby acknowledge that this prescription was originally prescribed by my American doctor whose name is _____ and that I will continue to have my medical condition and medications obtained in Canada under monitor by my American doctor.

In consideration of approving this prescription and in consideration of Medicine Shoppe Pharmacy making this prescription, I agree not to sue Medicine Shoppe Pharmacy, the signing physicians, employees, officers, agents and all others acting through or for it, from all legal liability for any problems associated with the prescription.

I hereby agree that the relationship between and the resolution of any and all disputes arising between me and Medicine Shoppe Pharmacy, signing physicians, employees, officers, agents and all others acting through or for it, be governed by and construed in accordance with the laws of the Province of British Columbia, Canada.

I hereby acknowledge that the Courts of British Columbia shall have jurisdiction to entertain any complaints, demands, claims or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the signing of this prescription, and I hereby agree that I submit irrevocably to the exclusive jurisdiction of the Courts of the Province of British Columbia.

I hereby acknowledge that by ordering medication internationally for delivery via Canada Post and the United States Postal Service, my package and/or contents may incur damages related to the shipping process. Upon entry to the United States of America, my medication may also be inspected by U.S. Customs and Border Protection and the United States F.D.A. The Medicine Shoppe Pharmacy is not liable for any damage incurred during inspection or shipment

All of which is agreed.

## Personal Medical History

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1) Blood disorders * | ☐ | ☐ | 2) Cancer * | ☐ | ☐ |
| 3) Immune disorders * | ☐ | ☐ | 4) Poor wound healing * | ☐ | ☐ |
| 5) Neurological disorders * | ☐ | ☐ | 6) Diabetes, thyroid or other endocrine disorders * | ☐ | ☐ |
| 7) Known nutrition deficiency including minerals or electrolytes * | ☐ | ☐ | 8) Lipid or cholesterol disorder * | ☐ | ☐ |
| 9) Heart disease including atherosclerosis, angina, heart failure or history of heart attack * | ☐ | ☐ | 10) Renal or kidney disease * | ☐ | ☐ |
| 11) Liver disease * | | | 12) Drug Allergies * | ☐ | ☐ |
| 13) Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome * | ☐ | ☐ | 14) Emotional disorders * | ☐ | ☐ |
| 15) Surgery * | ☐ | ☐ | 16) Glaucoma * | ☐ | ☐ |
| 17) Hyperlipidemia (high cholesterol) * | ☐ | ☐ | 18) Chemical dependency * | ☐ | ☐ |
| 19) Upper respiratory disorders * | ☐ | ☐ | 20) Smoker * | ☐ | ☐ |
| 21) Medications used in the last 12 months * | ☐ | ☐ | 22) Lung disorder (i.e., asthma, emphysema) * | ☐ | ☐ |
| 23) Rheumatoid arthritis, lupus, or connective tissue diseases * | ☐ | ☐ | 24) High blood pressure * | ☐ | ☐ |
| 25) Other illness not listed above * | ☐ | ☐ | | ☐ | ☐ |

**(If answered yes to any of these questions, please explain further)**

## Current Medications

| Medication | How long have you been on this? | Strength | Dosage | Condition | Is it effective (Yes/No) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Signatures of Consent

**Printed Name of Patient:** _____

**Signature of Patient** _____ **Date:** _____

**Printed Name of Witness** _____

**Signature of Witness:** _____ **Date:** _____

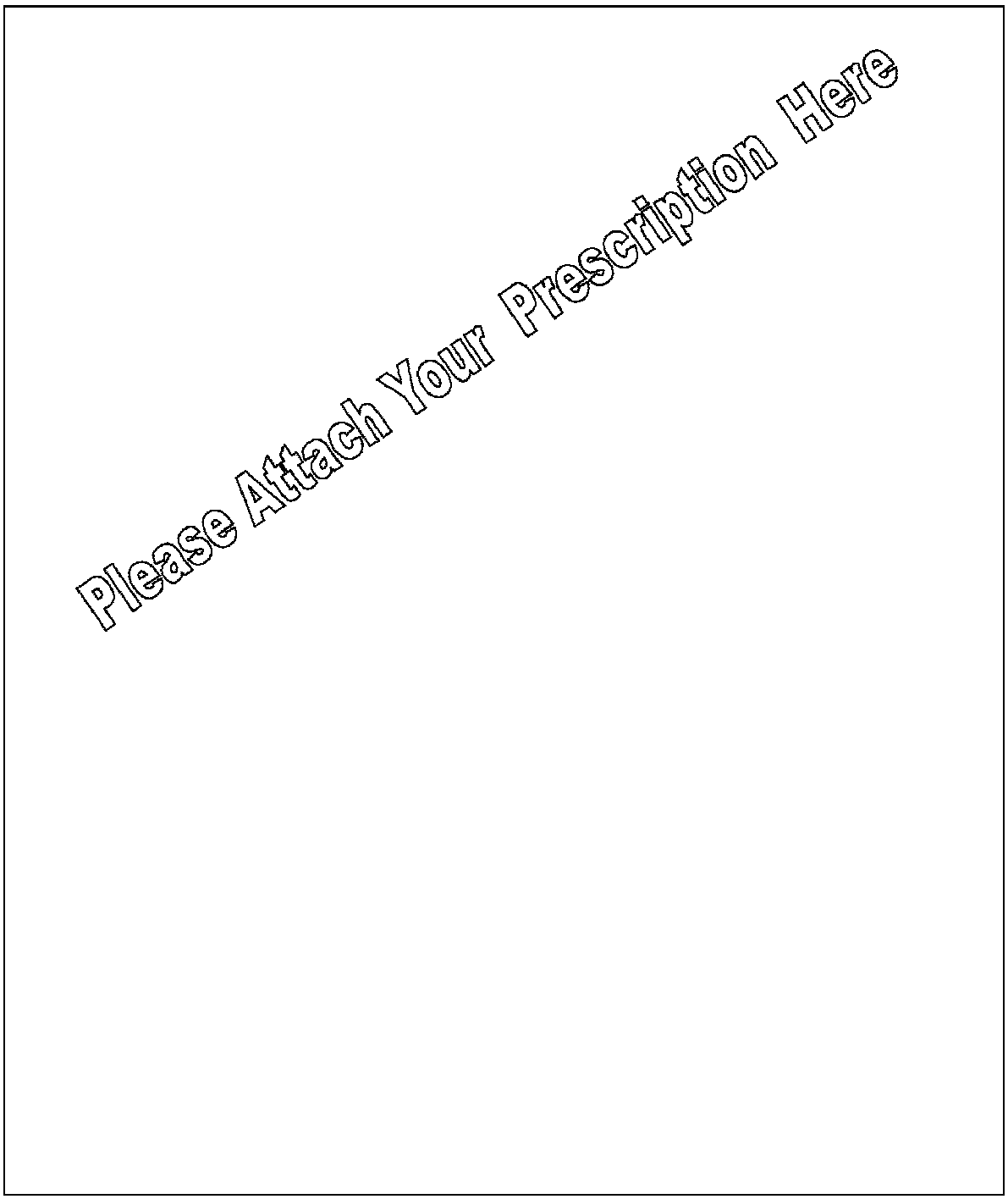
**Relationship to Witness:** _____

## Requested Medications (medications you wish to purchase)

| Drug Name/Brand | Brand Name Only | Quantity Requested | Dosage |
|---|---|---|---|
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |
| | ☐ | | |

| | |
|---|---|
| **Check here if you would like easy open lids** *(pills are counted at pharmacy and put in an easy open container)* | ☐ |
| ***Check here if you would like in manufacturers bottles with screw top lids****(comes in sealed container that does not get opened by us prior to shipping so you are assured of contents but there may be a small desiccant present)* | ☐ |
| **Check here if you would like child proof containers***(for families with small children, you must line up the arrows and pop off the top)* | ☐ |

****Please Note your order must include a copy of photo id and a prescription in order to be filled**


Please Attach Your Prescription Here