MAIL ORDER MEDS

PHONE 1-888-727-0726
Direct Dial: (587) 329-7382

FAX 1-888-727-0653
Direct Dial: (587) 329-7383

INTERNET mailordermeds.com
order@mailordermeds.com

MAILING ADDRESS: 612 - 500 Country Hills Blvd NE, Suite 309, Calgary, AB, Canada T3K 5K3

NEW PATIENT ORDER FORM (1 of 2)

Personal Information

First Name (Please print clearly) _____ Last Name _____ Male ◯ Female ◯

Please check if you are placing this order for a pet. Cat ◯ Dog ◯ Other _____ Pet Name _____

Street Address _____

City _____ State/Province _____ Country _____ Zip/Post Code _____

Phone Number _____ Daytime Phone Number _____ Fax Number _____ Date of Birth (MM/DD/YYYY) _____

When it is time to be contacted to remind you of future refills notify me by: Phone ◯ Email ◯ Text Message ◯

Best time to be contacted _____ Email _____

Secondary Contact

◯ *I authorize the following person to communicate on my behalf fully in all matters:*

First Name of Secondary Contact (Please print clearly) _____ Last Name of Secondary Contact _____

Relationship _____ Phone Number _____

Power of Attorney

I, _____ , being of sound mind and body, over the age of majority, hereby authorize _____ , my, _____ , to be my authorized representative to receive from and provide to Mail Order Meds information with respect to my medication purchases, including medical, financial, and other personal information, as well as to place an order on my behalf. I understand that I am responsible for any charges on my account for orders placed by my authorized representative. _____ Initial here.

Patient Authorization (Please Check One)

Mail Order Meds operates as an online marketplace and advertising platform where licensed pharmacies carry on business and display their products and services to the public. As a condition of the sale of any product or service (the "Products") from a pharmacy operating on Mail Order Meds (the "Pharmacy"), you (the "Patient") authorize Mail Order Meds to collect and use your personal information, order information, and/or payment information, and represent and warrant to the Pharmacy that,

◯ *"I am over the age of majority, and:*

OR

◯ *"I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."*

AND

1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy. I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.
2. I understand that all Products shall be sold & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.
3. I authorize and appoint the Pharmacy, as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.
4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy shall govern all transactions, and I attorn to the courts of the jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the Pharmacy, its affiliates, officers and directors.
5. I have read and agree to the Terms of Sale https://mailordermeds.com/termsofsale and that they shall govern the purchase of all products and services.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."

SIGNATURE: _____ DATE: ___/___/___

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NEW PATIENT ORDER FORM (2 of 2)

Current Medical Information

Height (Feet) _____, (Inches) _____, Weight (Pounds) _____, Smoking Yes ◯ No ◯, Currently or trying to get pregnant Yes ◯ No ◯

Do you have any known drug allergies? Yes ◯ No ◯ If yes, what are they: _____

Medication, OTC, Herbal Products You Are Currently Taking

(only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

Medications Order

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, emailed or called in from your Doctor). PRICING IN $US DOLLARS.

GENERIC OK?	MEDICATION	STRENGTH	QUANTITY	PRICE
	* *FREE for the US (incl. U.S. Territories)* **ALL OTHER COUNTRIES $24.**		*SHIPPING*	**FREE**
			TOTAL	

Payment Options (Please Select One)

1. *(ACH) Direct Bank Withdrawal*

◯ I will fax or email a void check to one of the following:
info@mailordermeds.com
Fax: 1-888-727-0653

PERSONAL CHECK

2. Please make checks payable to **MOM Mail Order Services** and send to:

◯ Mail Order Meds
612 - 500 Country Hills Blvd NE, Suite 309
Calgary, AB, Canada T3K 5K3

OR

3. *CREDIT CARD* ◯ VISA ◯ MASTERCARD (Sorry, NO Discover or Amex)

Cardholders Details

First Name (Please print clearly) _____ Last Name _____

Street Address _____

City _____ State/Province _____ Country _____ Zip/Post Code _____

Credit Card Number _____ / _____ / _____ / _____ Expiry Date (MM/YY) _____ / _____ CVV Code _____

NOTE: Not all pharmacies are able to take Credit Cards for payment. You may call ahead to verify, or we will call you if alternate payment needs to be arranged.

MAIL ORDER MEDS

PRESCRIPTION SUBMISSION

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MAILING ADDRESS: 612 - 500 Country Hills Blvd NE, Suite 309, Calgary, AB, Canada T3K 5K3

Please use this form to submit your prescription(s), and send it back to us to complete your order.

First Name (Please print clearly) _____ Last Name _____ Phone Number _____

Patient ID ☐☐☐☐☐☐☐☐ Order ID ☐☐☐☐☐☐☐☐

Your Physician

Primary Physician's Name _____ Clinic Name _____

Street Address _____

City _____ State/Province _____ Country _____ Zip/Post Code _____

Phone Number _____ Ext _____ Fax Number _____

Email: _____

◯ **Option 1 (FASTEST)** Email or Fax a copy of your prescription(s) and then mail originals.

Scan or use your camera (smartphone) to take a clear picture of your original prescriptions, then email them in full quality to:

To: rx@mailordermeds.com
Subject: Prescription(s) for (type your name)

OR

Fax: 1-888-727-0653

◯ **Option 2** Contact Your Doctor*

Please list the prescriptions you would like us to request from your Doctor for your order.

DRUG NAME	STRENGTH	DIRECTIONS	RX NUMBER

* Contacting your doctor is only available to residents of the United States and Canada

Referral Rewards Program

Save 25% on your first order! Simply share with us who referred you.*

First Name of person who referred you (Please print clearly) _____ Last Name of person who referred you _____

Phone Number _____ Patient ID# ☐☐☐☐☐☐☐☐

***Referrer must be an exsiting patient with a previous order to qualify**

Visit mailordermeds.com for more information

◯ **Please send me a Referral Rewards Program package**