



## Patient Disclaimer

I hereby release Ontario Pharmacy License # 038132, including all of its employees, agents, representatives and contractors including physicians, pharmacists, pharmacy technicians, nurses, and receptionists ("Pharmacy") from any and all liability whatsoever associated with or connected to my use of this website, including consultation, the late delivery, non-delivery or missed delivery, and the use of any or all the medications dispensed to me or services provided by Pharmacy and any adverse effects I may suffer from these medications dispensed by Pharmacy. I hereby state that I am at least eighteen (18) years old and am fully competent to make my own health care decisions. I am aware of the potential side effects and/or problems associated with prescription medications, including the medications being dispensed by Pharmacy. I agree to truthfully and to the best of my knowledge enter all of the information on my medical registration.

I understand and acknowledge that because medical diagnoses, treatments, and opinions differ among the very best, well-trained, and respected pharmacists, there is no implied warranty that treatments may benefit me. I also acknowledge that medical and pharmaceutical opinions may differ from time to time depending upon many factors such as medical research, conventions, literature, etc. Any and all questions that I have about my prescription medications and their attendant risks have been answered to my satisfaction. I understand all of the material risks and/or complications that may occur.

I also fully understand and agree that by signing this document, I give the licensed Canadian physician who reviews my prescription(s) the right to contact my US prescribing physician(s) with any questions regarding my prescription(s), and/or my medical history. I also agree that if I become aware of any changes in my physical or medical condition in the future and I fail to notify Pharmacy of such changes, then I agree that I am solely responsible for any adverse effects I may suffer from taking or continuing to take these prescribed medications or from participating in this prescription service. I also state that I have had a physical examination by the physician whose care I am under within the last twelve months.

By signing each of these pages of this waiver, or clicking "I AGREE" if being submitted electronically, I agree to release from liability and hold harmless Pharmacy from all claims, actions, causes of action, suits, penalties, liens, judgments, liabilities, obligations, losses, and actual, claimed or consequential damages which may arise at any time by reason of or relating to, arising directly or indirectly out of any matter whatsoever related to the dispensing of my prescription medications or other use of this website.

I understand that it is my responsibility to have regular physical examinations by the physician whose care I am under including all suggested testing by said physician to ensure I have no medical problems which could constitute a contraindication to me taking the medications being prescribed and dispensed for me.

I agree that should I suffer any adverse effects while taking these prescribed medications that I will immediately contact the physician whose care I am under. Should I come under the care of another physician, I will inform him or her of any and all medications I am taking.

I hereby give permission to my physician to release my medical files and medical reports to Pharmacy as needed to obtain sufficient information for the purpose of dispensing my medications.

I acknowledge and agree that I initiated this contract with Pharmacy and that it is located in Canada. I acknowledge that the pharmacists working with Pharmacy are licensed to practice pharmacy in Ontario - Canada. I hereby authorize Pharmacy to redirect my prescription for fulfillment of any medications that are temporarily unavailable in Canada and for all controlled medications that cannot be mailed from Canada to a fully licensed United States mail order pharmacy.

I understand and acknowledge that Pharmacy recommends regular physical examinations and doctor's office visits with my physician. I further understand that Pharmacy will only verify and dispense medications that my physician whose care I am under has already prescribed for me. I also understand that no controlled medications, narcotics, tranquilizers, or other medication the physician decides is inappropriate will be dispensed.

I understand that this service is not in any way intended to diagnose a medical condition. I will direct all questions to my own health care provider. I will consult my own physician before taking any new drug or changing my daily health regimen. I understand that any opinions, advice, statements, services, offers, or other information expressed or made available by third parties (including merchants and licensors) are those of the respective authors or distributors of such content.

Pharmacy reserves the right to change this disclaimer and the medical registration form at any time, including the terms of consultations. You should read this disclaimer every time you place a new prescription order.

Liability in regards to Deception or other Misuse:

In rendering the undersigned patient any administrative or other services relating in any way to this agreement, or disclosing information or methods of treatment to the patient (either deemed to be sufficient consideration for this agreement) then, in the event any court determines that the undersigned patient sought medical treatment or prescriptions for the possible or apparent purpose of deception, or any other misuse, directly or indirectly, the undersigned patient knowingly and expressly consents to a judgment of liquidated damages, against the undersigned patient, in the amount of Five Million Dollars (\$5,000,000.00 (U.S.)), which amount is hereby accepted by the undersigned as a reasonable amount for engaging in such acts of deception. If the undersigned patient engages in any of the above-described acts, he/she agrees to pay all reasonable attorney's fees and costs incurred by any legal person seeking to enforce this agreement.

This agreement represents the complete and entire agreement between Pharmacy and myself. I have read and understood the above-referenced "Patient Disclaimer". I declare that I understand this Disclaimer.

Signature: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_



## Registration Form

<b>Personal Information:</b>				
Last Name	First Name	Group	Birth date	Gender
		<b>PAP</b>		M F
<b>Contact Information:</b>				
Address		City	State/Prov	Zip
Phone	Fax	E-mail		
<b>Medical Information:</b>				
Medications Currently Taking				
Allergies:				
Medical Conditions (Please Check)				
Pregnancy	Asthma	Cholesterol	Diabetes	Bleeding Disorder
Glaucoma	Heart Condition	Hypertension	Others	
If Check Others, Please Specify:				
<b>Rx Refill Options:</b>		Refill by E-mail		Refill by Phone
<b>Accept Generic Substitute:</b>		Yes		No
<b>Your Doctor Information:</b>				
Doctor Last Name	First Name	Phone	Fax	
Doctor Address		City	State/Prov	Zip
<b>Shipping Information (If not the same as contact information above)</b>				
Shipping Address		City	State/Prov	Zip
Shipping insurance is mandatory for orders above \$100 Canadian Dollars.				
<b>Credit Card Information:</b>				
Card Holder Name (on card)			Card Number	
<b>Method of Payment (check only one):</b>				<b>Expiration (MM/YY)</b>
Visa	MasterCard	AMEX	Discover	E-Check

By signing below, I authorize Pharmacy License # 038132 to check the accuracy of the personal information I have provided. I understand that in order to verify my personal information, Pharmacy License # 038132 may disclose my personal information to the third parties and such third parties may provide verification of such personal information to Pharmacy License # 038132 from information they have previously collected about me. I also acknowledge that due to the nature of this business, **all orders received are considered Final and no medications can be returned once shipped.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Customs Statement

The undersigned hereby acknowledges, confirms and certifies that the enclosed medications are imported to the USA solely for personal use for a period not exceeding 3 months.

These medications are prescribed by the following Doctor(s):

Primary Doctor: \_\_\_\_\_ License # \_\_\_\_\_

Other Doctor: \_\_\_\_\_ License # \_\_\_\_\_

Other Doctor: \_\_\_\_\_ License # \_\_\_\_\_

(If you do not know your Doctor's license #, the pharmacy will attempt to acquire it.)

<b>FOR PHARMACY USE ONLY</b>
Authorized by Doctor: _____;
who holds a Ontario License # _____
Phone #: _____

The above-mentioned doctor(s) is/are responsible for my treatment with regard to the enclosed medication(s); a copy of my prescription(s) is available.

**Patient Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_