Your Canadian Meds

4871 Shell Road, Suite 1115
Richmond, BC, Canada V6X 3Z6
Toll Free Phone: 1-877-210-3784 • Toll Free Fax: 1-877-210-3777 • www.YourCanadianMeds.com

How To Place Your Order: New Customer Application

WB-YCM

STEP 1: Obtain a prescription from your physician for the medications you would like to order. For maximum savings, we recommend you order in bulk, therefore have your doctor write you a **one year prescription in the form of a 3 month supply and 3 refills for EACH medication**. **If you prefer, we can contact your doctor to obtain the prescriptions on your behalf.**

STEP 2: Complete and sign the **Patient Information Form**, the **ORDER INFORMATION & BILLING AUTHORIZATION FORM**, and the **CLIENT AGREEMENT & AUTHORIZATION FORM**. Fax all completed forms and **ORIGINAL PRESCRIPTIONS** to us at **1-877-210-3777**. You can also mail this information to our processing office using the following address: **Your Canadian Meds, 4871 Shell Road, Suite 1115, Richmond, BC, Canada V6X 3Z6**. Please allow 8-12 business days from the day we receive your order for processing and delivery of your prescriptions. Orders are shipped using Canada Post and are fully insured against loss or damage.

Patient Information Form

*** Indicates Mandatory Fields**

OFFICE USE ONLY	AGENT ID:	ORDER ID:

***First Name**:	***Last Name**:	***Sex (M or F):**
***Date of Birth**: _____/_____/_____ (mm/dd/yy)	***Height**: _____ Ft. _____ Inches	***Weight**: _____ lbs
***Home Tel**: ( )	***Secondary Tel**: ( )	**Fax**: ( )
***Shipping Address**: Street & Apt. # (**PRINT CLEARLY**)		**Email Address**:

***City**:	***State**:	***ZIP**:	**How did you hear about us?**

Personal Medical Profile

***Primary Physician's Name**:	***Physician's Tel**: ( )

***Please indicate ALL known drug allergies**: (if none, please mark none)

***Please indicate ALL medications currently being taken**: (also indicate strength and frequency for each drug)

***Please indicate if you've ever experienced any of the following: (answer by circling YES or NO)**

▪ Smoker	Yes	No	▪ Emotional mood disorders	Yes	No
▪ Glaucoma or other eye disorders	Yes	No	▪ Musculoskeletal & Arthritic disorders	Yes	No
▪ Respiratory disorders (breathing problems)	Yes	No	▪ Cancer	Yes	No
▪ Heart disease: high blood pressure, heart disease, angina, heart failure, heart attack, arrhythmias or heart surgery.	Yes	No	▪ Blood disorders	Yes	No
▪ High lipids and triglycerides	Yes	No	▪ Neurological disorders	Yes	No
▪ Stomach, liver, intestinal disorders	Yes	No	▪ Dermatological disorders	Yes	No
▪ Renal or kidney disease including prostate disease	Yes	No	▪ Other: Please specify below	Yes	No
▪ Diabetes, thyroid or other endocrine disorders	Yes	No			

***If you have answered YES to any of the above, please elaborate:**

***Patient/Client Signature:**	***Date:** _____/_____/_____ **(mm/dd/yy)**

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Order Information & Billing Authorization

*** Indicates Mandatory Fields**

***Medications Being Ordered**

***Drug Name**	**Strength**	**Quantity**	**Generics (Y or N)**	**Price (USD)**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Shipping and handling fees are $13.00 per package. Husband and wife orders submitted at the same time and shipped in the same package to the same address are only charged a single shipping fee.		**Shipping & Handling:**		
		Order Total:		

***Patient Consultation & Additional info**

***Would you like us to contact your doctor to obtain prescriptions for this order?**	**YES**	**NO**
***Do you require a pharmacist to contact you to provide patient counseling?**	**YES**	**NO**
***Do you require child-proof safety caps for your medications?**	**YES**	**NO**

***Payment Information**

***How would you like to pay for your medications?** (Please make all money orders payable to **Canada Health Solutions**)

____ Visa	**____ MasterCard**	**____ AMEX**	**____ Discover**	**____ Money Order**	**____ E-Check (Direct Debit)**

***Name on Credit Card:**	***Credit Card Number:**
***Credit Card Verification Number:** (The verification number is a 3-digit number printed on the back of your card. It appears after and to the right of your card number on the signature field.)	***Card Expiry Date: _____/_____ (mm/yy)**
***Cardholder/Billing Address: Street & Apt. # (If different from above)**	

***City:**	***State:**	***ZIP:**

***If E-Check is your method of payment, please complete the following: (Please also complete Billing Address section above)**

***Bank Name:**	***Driver's License/State ID Number:**
***Bank Routing Number (9 digits):**	***Bank Account Number:**

***Billing Authorization**

I, the undersigned card/account holder, authorize **Canada Health Solutions Inc**., a provider of prescription fulfillment and billing services for **Your Canadian Meds**, to apply all applicable charges to my credit card/account. These charges include the total cost of the drugs ordered, including refills on prescriptions submitted within 90 days, and any applicable shipping and handling fees, which are applied to each package Canada Health Solutions ships me. I understand that a 90-day supply of each medication will be shipped, unless otherwise specified. I also understand that generic substitutions will be made when available, unless otherwise specified, and that all prices and dollar amounts are in United States dollars.

***Cardholder Signature:**	***Date**: _____/_____/_____ (mm/dd/yy)

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Client Agreement & Authorization

This Client Agreement and Power of Attorney, also known as Client Agreement and Authorization, (this "**Agreement**"), consisting of two (2) pages, must be signed, dated and delivered to **Canada Health Solutions Inc.** ("**CHS**"), a provider of international prescription fulfillment services, by any customer or client ("**I**" or "**me**") who is purchasing prescription medications ("**Medications**") through **CHS** by using the **CHS** prescription service. I acknowledge and agree with **CHS** as follows:

1. If placing this order as a customer, I, on behalf of myself, my heirs, assigns and successors, hereby agree to all of the following terms and conditions, represent that I understand all of the following terms and conditions and that I have had adequate opportunity to consult any advisors necessary, whether medical, legal or otherwise.
2. If I am placing the order on behalf of someone else, I represent that I have all necessary consent, permission and authorization to do so on behalf of that person and their heirs, assigns and successors and the person I represent agrees to all of the following terms and conditions, understands all of the following terms and conditions and has had an adequate opportunity to consult any advisors necessary, whether medical, legal or otherwise.

   In the case of paragraph 1 above, if I do not agree with all of the following terms and conditions, I agree that I will not place any orders. In the case of paragraph 2 above, if I do not have that person's consent, permission or authorization or that person does not agree with all of the terms below, I agree that I will not place any orders.
3. I understand and acknowledge that all prescriptions, including all prescription dispensing and patient medication consultation services, are being provided by a **CHS** partnered licensed Canadian and/or International pharmacy and that the information and services provided by **CHS** are strictly for the purposes of assisting me in filling a prescription prescribed by a qualified physician licensed where I obtained the prescription. Furthermore, I understand and acknowledge that the medications I order through **CHS** may be dispensed and shipped by a licensed pharmacy located in a country outside of Canada (each referred to as an "**International Pharmacy**") and that these countries can include, but are not limited to, Great Britain (UK), United States, Australia, Chile, Israel, New Zealand, Italy, Scotland, Ireland, Argentina, Turkey, and other European Union (EU) nations. I further acknowledge that I have been made expressly aware of the specific country or countries my medication order(s) will be processed, dispensed and shipped from, and that I voluntarily consented and authorized **CHS**, its affiliates, contractors, and agents to facilitate the processing of my prescriptions through these countries.
4. I acknowledge that **CHS** is required to have a licensed Canadian and/or International Physician (the "**Canada MD**" and "**International MD**" respectively) review my medical information and that **CHS** and its delegates, employees and contractors have relied on the information and documentation provided by me and I represent that I have fully disclosed all pertinent requested information and documentation to **CHS**. I understand and acknowledge that the International MD is a medical physician fully licensed in a country outside of Canada. I hereby waive any requirement to have the Canadian and/or International MD conduct a physical examination of me. I acknowledge that there are no fees charged to me arising from the Canadian and/or International MD reviewing my medical information. If there is any change to my physical or medical condition or any change in medications I am taking, I shall notify **CHS** of such changes by providing an updated patient profile and medical history questionnaire at the time I am ordering additional medications. I certify that I have had a physical examination by a doctor licensed to practice medicine in the country, state, or other applicable jurisdiction in which I reside ("**My Own Physician**") within the last 12 months from the date hereof.
5. I hereby give permission to **My Own Physician** to release any and all medical information and data whatsoever which **CHS**, the Canadian and/or International Physician or Pharmacist shall request for the purpose of performing a medical review to determine whether the Medications prescribed by My Own Physician are appropriate in the circumstances. I understand that this will include reviewing the medical questionnaire and information submitted by My Own Physician and that **CHS**, the Canadian and/or International Physician or Pharmacist may contact My Own Physician for more information.
6. I understand that it is my responsibility to have My Own Physician conduct regular physical examinations of me, including any and all suggested testing by My Own Physician to ensure that I have no medical problems which would constitute a contradiction to me taking medications prescribed by My Own Physician. I agree that should I suffer any adverse affects while taking any prescription medication that I will immediately contact My Own Physician and that in the event I come under the care of another physician, I will inform him or her of any and all medications that I have been prescribed.
7. **I AGREE THAT THE CANADIAN AND/OR INTERNATIONAL PHYSICIAN SHALL NOT BE LIABLE FOR ANY LIABILITY, CLAIM, LOSS, DAMAGE OR EXPENSE OF ANY KIND OR NATURE CAUSED DIRECTLY OR INDIRECTLY BY ANY INADEQUACY, DEFICIENCY OR UNSUITABILITY OF ANY PRESCRIPTION ISSUED BY THE CANADIAN AND/OR INTERNATIONAL PHYSICIAN OR THE INADEQUACY, DEFICIENCY OR UNSUITABILITY OF THE CANADIAN AND/OR INTERNATIONAL PHYSICIAN'S REVIEW OF MY MEDICAL INFORMATION. IN NO EVENT WILL THE CANADIAN AND/OR INTERNATIONAL PHYSICIAN BE LIABLE OR RESPONSIBLE FOR ANY DAMAGES WHATSOEVER, INCLUDING, DIRECT, INDIRECT, PUNITATIVE, SPECIAL OR CONSEQUENTIAL DAMAGES, EVEN IF ADVISED OF THE POSSIBILITY THEREOF.**

Authorization, Consent and Power of Attorney

* I hereby authorize and appoint **Canada Health Solutions Inc.** and its agents, affiliates, employees and contractors as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription from a licensed Medical Doctor in Canada or other country that is the equivalent of the prescription included in this order, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to **CHS** employees, agents, affiliates, contractors, and service providers including the Canadian and/or International Physician being retained on my behalf, as required, for the limited purpose of obtaining the Canadian and/or International prescription, and purchasing and arranging delivery of the medications prescribed in the Canadian and/or International prescription.
* I hereby consent to **CHS**, the Canada and International MD, and any licensed Canadian and International Pharmacy supplying my order, collecting my personal and medical information, maintaining the information necessary to quickly process future orders which may include retaining on file my name, address, phone number, medical information, payment and other information and verifying future orders.
* I confirm that my personal and medical information will be handled only by **CHS** order-processing employees and contractors (including physicians and nurses, pharmacists and pharmacy technicians) in accordance with **CHS's** Privacy Policy, which may be updated from time to time.
* I hereby acknowledge and understand that CHS will in all instances substitute generic drug equivalents unless specified otherwise by My Own Physician or myself. I also understand that CHS will in all instances use Canadian or International drug equivalents, including generics, to fill my order, and therefore brand names may vary. I understand and acknowledge that International drug equivalents refer to drug equivalents from countries outside of Canada.
* I hereby specifically acknowledge that I am aware that **CHS** will be transmitting my personal health information by electronic means (for example fax, secure internet) to its employees, agents, contractors, affiliates and service providers including the Canadian and/or International Physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that **CHS**, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to **CHS** 's transmission of my personal health information by electronic means.
* If I was directed to **CHS**'s services through an affiliate or intermediary (for example Pharmacy Benefit Manager, Health Management Organization, or other healthcare service provider), I hereby authorize **CHS** to release the following data to such an intermediary:

   a. a numerical identifier indicating that I was a patient referred from that source;
   b. financial information that will permit the processing of any claims on my behalf;

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Client Agreement & Authorization - continued

It is my understanding that all such intermediaries will enter into Confidentiality Agreements where they agree to abide by the privacy policies of **CHS** relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.

Disclosure And Representations

* I represent that ALL of the following statements are true and agree that **CHS** and its employees and contractors (physicians and nurses, pharmacists and pharmacy technicians) are relying on these representations:

1. I am of the age of majority or older where I reside;
2. I can make my own medical decisions according to the law of the country, state, or other applicable jurisdiction where I reside;
3. The prescription I am requesting **CHS** to assist me in obtaining was prescribed by a qualified physician licensed where I obtained the prescription;
4. The prescription I am requesting **CHS** to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to **CHS**. I agree to immediately destroy all copies of my prescription once it has been filled;
5. The prescription I am requesting **CHS** to assist me in obtaining is not more than one year old from the date the prescription was originally written;
6. With respect to any of the medications which I now or hereinafter order from **CHS**, I will take the same for at least 30 days immediately prior to the date that I submit my order to **CHS**;
7. I am not violating any laws where I reside by placing this order;
8. I will use any medication obtained for me by **CHS** strictly according to the instructions provided by the physician who prescribed the medication;
9. I am placing this order for medication for my sole use and I will not provide any quantity of this medication to any other person;
10. I am not seeking or relying on any medical information from **CHS** and I have consulted a qualified physician licensed where I obtained the prescription within the last year; and
11. I will immediately contact the physician who provided my prescription included with this order in the event I suffer any unexpected side effects from any medication obtained for me by **CHS**.

* **Canada Health Solutions Inc.** has made no representations or warranties to me, including, without limitation, representations or warranties with respect to any delivered medications' usefulness or fitness for a particular purpose (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).

Purchase And Sale Terms

* **CHS** will charge my credit card the following amounts for each order: the **TOTAL COST OF THE MEDICATIONS** as posted on the **CHS** Website or **CHS** internal pricing system on the day **CHS** receives my order and **SHIPPING AND HANDLING COST** for each package **CHS** ships.
* In the event my payment is not authorized**, CHS** has the right to cancel my order and attempt to provide me with notice of such cancellation.
* **CHS** will charge my credit card a $20 fee for each cancelled order
* **CHS** reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund for monies paid for such order.
* **CHS** does not provide its agent or attorney services as a substitute for health care or the advice of a physician.
* **CHS** will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription.

Release And Waiver

* I hereby release and save **CHS** and its employees, officers, directors, delegates, agents, affiliates and contractors (including physicians and nurses, pharmacists and pharmacy technicians) harmless from any and all suits, demands, liabilities, claims, actions, expenses, losses and damages of any kind or nature whatsoever, including, without limitation, general, direct, special, indirect and consequential damages and costs of litigation (including reasonable attorney fees) arising from:

1. my use of the medication obtained for me by **CHS** including, without limitation, any and all side effects whether previously known or unknown;
2. **CHS** or its contractors' manner or timeliness of completing any actions I have authorized above, including, without limitation, their manner or timeliness in prescribing the appropriate strength, dosage, or dispensing generic drugs and non-child-protective packaging; and
3. my breach of any terms, conditions or representations or warranties in this agreement.

Nothing in this release shall be deemed to release any **CHS** pharmacy or pharmacist contractors from compliance with the applicable standards of practice or usual professional duties and obligations, which a pharmacist owes.

* If any term or provision of this agreement is determined to be invalid or unenforceable by any court, such determination shall not invalidate the rest of this agreement which shall remain in full force and effect as if the invalid term or provision had not been made part of this agreement.

Governing Law

* I agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and **CHS** shall be deemed to be made in the **Province of British Columbia, Canada and accordingly shall be governed by the laws of the Province of British Columbia and the laws of Canada applicable to such contracts and agreements.**

I, the client, have read, understood and agree to all of the foregoing in this two (2) page document entitled 'Client Agreement & Power of Attorney'.

Client Printed Name _____ **Client Signature** _____

Date (Day/Month/Year) _____