

Canadian Meds

Canadian Meds Savings Center
 3850 E. Gulf to Lake Hwy
 Unit 5 Inverness, Florida
 USA 34453
 Tel: 1-866-250-7050
 Fax: 1-352-637-4617

Instructions for completing this form and getting your medications:

1. Please complete the PATIENT INFORMATION FORM below.
2. Read and *sign* the AUTHORIZATION & RELEASE FORM.
3. Get your PRESCRIPTIONS from your doctor(s).
4. Fax the PATIENT INFORMATION FORM, AUTHORIZATION & RELEASE FORM SIGNATURE PAGE and your PRESCRIPTIONS to our toll free fax number listed on the bottom of this page. You can also mail it to:
 Canadian Meds Savings Center
 3850 E. Gulf to Lake Hwy
 Unit 5 Inverness, Florida
 USA 34453

Please be advised to contact Canadian Meds Savings Center 2-3 weeks prior to requirement of refill prescriptions. Tel: 1-866-250-7050 Fax: 1-352-637-4617

Patient Profile Form

* Fields must be filled to be valid

*Last Name:	*First Name:
*Telephone: ()	*Alternate Phone: ()
*E-Mail Address:	*Sex <input type="checkbox"/> male <input type="checkbox"/> female
*Height: ft. inches	*Weight: lbs.
*Date of Birth (MM/DD/YY): / Age:	*Mailing Address: Apt #/Street:
*City:	*State/Zip Code:

* How did you find Canadian Meds Savings Center?

<input type="checkbox"/> Internet (search engine, link, email)	<input type="checkbox"/> Print Ad
<input type="checkbox"/> Relative	<input type="checkbox"/> Doctor
<input type="checkbox"/> Friend	<input type="checkbox"/> Other

Be Sure to Complete Both Sides of Form
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* Have you previously filled out this form?

* (Please check one appropriate field)

<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes please describe any changes to your health, medications, or exercise routine since the last time you gave information:	

*What medical condition(s) are you being treated for?

*Are you receiving any medications from another physician?

* (Please check one appropriate field)

<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe:	

*List known drug allergies:	*Other medications in use (include non-prescription)
1	1
2	2
3	3

*Patient Signature:	*Date: (MM/DD/YY)
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*HOW WILL YOU BE PAYING?

<input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> Money Order <input type="checkbox"/> Certified Check	
*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)
*Credit Card Expiry Date: (MM/YY)	

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Billing Address <i>(if different from above)</i>	Suite #:
Street Address:	Zip / Postal Code:
City:	State/Province:
*Cardholder Signature:	
*Date (MM/DD/YY):	

Authorization & Release Form

*Patient Signature:	*Witness Signature:
*Patient Printed Name:	*Witness Printed Name:
*Date:	*City/Town where signed:

By signing above, I agree to all of the following terms and conditions on behalf of myself, my heirs, assigns and successors. I further 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. In the event that I am placing the order on behalf of someone else, I also represent that I have all necessary consent, permission and authorization to do so on behalf of that person and their heirs, assigns and successors.

AUTHORIZATION AND CONSENT

I hereby appoint Candrug Health Solutions Inc. ("Canadian Meds Savings Center") and its delegates (Canadian Meds Savings Center) as my agent and attorney for the purposes of obtaining a prescription from a medical doctor in Canada (the "Canadian Doctor") that corresponds to the prescription included in this order. The acts authorized may include directly contacting my prescribing medical practitioner, and purchasing and arranging delivery of the medications prescribed in the Canadian prescription, substantially on the terms set forth below, and all to the same extent that I could if I personally took such steps. I hereby consent to and authorize CANADIAN MEDS SAVINGS CENTER, the Canadian Doctor and any Canadian pharmacy with which CANADIAN MEDS SAVINGS CENTER may partner (the "Partnered Canadian Pharmacy") to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my name, address, phone number and payment information. I understand that my personal information will be handled only by CANADIAN MEDS SAVINGS CENTER, the Canadian Doctor, and the Partnered Canadian Pharmacy's processing employees and contractors (including physicians and nurses, pharmacists and pharmacy technicians).

DISCLOSURE AND REPRESENTATIONS

I represent that all of the following statements are true and understand that CANADIAN MEDS SAVINGS CENTER, its Partnered Canadian Pharmacy, their employees and contractors (physicians and nurses, pharmacists and pharmacy technicians) are relying on the following representations:

1. I am of the age of majority or older according to the laws of the state in which I reside ("My Place of Residence").
2. I can make my own medical decisions according to the laws of My Place of Residence.

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3. A duly qualified medical practitioner in My Place of Residence (“My Medical Practitioner”) prescribed the pharmaceutical product(s) (“the Ordered Product”) that I am requesting CANADIAN MEDS SAVINGS CENTER to assist me in obtaining.

4. The prescription that I am requesting CANADIAN MEDS SAVINGS CENTER to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to CANADIAN MEDS SAVINGS CENTER. I agree to immediately destroy all copies of my prescription once it has been filled.

5. I will use any medication obtained for me by CANADIAN MEDS SAVINGS CENTER strictly in accordance with the instructions provided by My Medical Practitioner.

6. I place this order for medication for my sole use and I will not provide any of this medication to another person. I am not seeking or relying on any medical information from CANADIAN MEDS SAVINGS CENTER.

8. I will immediately contact My Medical Practitioner in the event I suffer any unexpected side effects from any medication(s) provided to me by Canadian Meds Savings Center’s Partnered Canadian Pharmacy. CANADIAN MEDS SAVINGS CENTER has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use or fitness for any particular purpose of the medication(s) delivered (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

- If I choose to pay for my order by credit card, CANADIAN MEDS SAVINGS CENTER and the Partnered Canadian Pharmacy will charge my credit card the following amounts (all prices in US funds): the medication price as posted on CANADIAN MEDS SAVINGS CENTER’s website on the day CANADIAN MEDS SAVINGS CENTER receives my order, and a \$10.00 Shipping/Insurance Fee for each package CANADIAN MEDS SAVINGS CENTER ships, and any applicable taxes.
- In the event my payment is not authorized by my credit card company, CANADIAN MEDS SAVINGS CENTER has the right to cancel my order and attempt in good faith to promptly notify me of such cancellation.
- CANADIAN MEDS SAVINGS CENTER reserves the right, in its sole discretion, to refuse to process any order, in which event I will be entitled to a prompt refund of all monies paid for such order, if any.
- Whenever possible, and unless otherwise instructed by My Medical Practitioner or by me, CANADIAN MEDS SAVINGS CENTER’s Partnered Canadian Pharmacy will substitute lower cost generic drugs for any prescribed brand name prescription drugs.
- CANADIAN MEDS SAVINGS CENTER does not fill any orders using child protection packaging.
- CANADIAN MEDS SAVINGS CENTER is not providing its services as agent or limited power of attorney as a substitute for health care or the advice of a licensed medical practitioner.
- CANADIAN MEDS SAVINGS CENTER 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 hold harmless CANADIAN MEDS SAVINGS CENTER, its Partnered Canadian Pharmacy, the Canadian Doctor, their officers and directors, agents, employees and contractors (including physicians and nurses, pharmacists and pharmacy technicians) 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(s) provided to me by Canadian Meds Savings Center’s Partnered Canadian Pharmacy including, without limitation, any and all side effects whether previously known or unknown;
2. The manner or timeliness of completion by CANADIAN MEDS SAVINGS CENTER or its Partnered Canadian Pharmacy of any of the actions I have authorized; and

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3. My breach of any terms, conditions or representations or warranties in this agreement.

GOVERNING LAW

This agreement, along with any disputes that may arise, will be governed by and construed in accordance with the laws of the Province of British Columbia, Canada.

I have read and understand all of the foregoing