In consideration of Discount Meds of Canada acting as my agent and arranging to have my prescriptions filled by a duly licensed pharmacy in Canada or other country, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by me, I hereby recognize that Discount Meds is NOT A PHARMACY and I understand that DMOC's sole function is to: TRANSMIT AND FORWARD INFORMATION.
Further, I also agree that:

Regarding my Medication(s)

1. I will be the only person using my medication(s) and I will use them as prescribed.
2. I understand that my medication(s) cannot be returned for exchange or refund.
3. I understand that DMOC's designated pharmacies may substitute a generic drug for a brand name prescription drug, where available, in accordance with the Manitoba and other Provinces' Drug Standards and Therapeutic Formulary, unless the physician has indicated there be no such substitution or if I do not want a generic substitute.
4. Medication(s) to be delivered to me were prescribed by a physician licensed to practice medicine in the country, state, or other applicable jurisdiction in which I reside.
5. The prescriptions for the medication(s) to be delivered to me were lawfully obtained from my physician.
6. The medication(s) to be delivered to me will be used only as directed and only by me.

My Information

1. I am of the age of majority and I am not restricted from making my own medical decisions.
2. By obtaining this/those prescription(s) for my ordered medication(s), I have not broken laws of that state.
3. It is my responsibility to have regular physical examinations by my U.S. licensed physician, including all suggested tests to ensure I have no medical problems that contraindicate my taking the medication(s).

Delivery of Medication(s)

1. I acknowledge that Discount Meds of Canada and its agents/pharmacies/Doctors rely solely on the health information that is provided by me. This includes my patient questionnaire and all other related information that is forwarded to the pharmacy. I confirm that I have, to the best of my knowledge, fully disclosed all pertinent information and documentation for my prescriptions
2. I understand that when possible, my medication(s) will be in original manufacturer's packaging, which may or may not be child resistant packaging, and I must indicate if I choose or choose not to have child resistant packaging.
3. I name and authorize Discount Meds of Canada as my agent for the limited purposes of taking all steps and signing all related documents on behalf of myself necessary to:

(a) Obtain a prescription in Canada for the prescription sent by me, to the same extent as if I were personally present taking those steps and signing those documents myself, including, but not limited to, collecting my personal health information and any other information required by the patient questionnaire, regarding me, directly from my prescribing physician or pharmacist, and disclosing that information to Discount Meds of Canada, the Canadian Pharmacies/Doctors, etc. for the limited purposes stated in this paragraph.
(b) Package or repackage the medication(s) and deliver them to myself to the same extent as the undersigned could do if he/she were personally present, taking those steps or signing those documents him/her.
(c) For shipping my medication(s) as if I had shipped the medication(s) to myself at my own address.

4. I acknowledge Discount Med of Canada to represent duly licensed pharmacies located in Canada and other countries, licensed by the Manitoba Pharmaceutical or other recognized Associations, and agrees that I have initiated the consultation. I also acknowledge that the previously referred to pharmacies use licensed pharmacists and have contracted physicians who are located and licensed to practice pharmacy or medicine, as the case may be, in Canada, and that all treatment I am receiving from the said pharmacists and physicians is being received in Canada.
5. I acknowledge that the Canadian cosigning physician evaluates my medical profile and may approve my prescription but is in no position to modify my medication(s). This relationship does not replace that of my primary physician.

6. Once drugs are shipped to you, they may not be returned or cancelled.

Release & Disputes:

1. I agree to the jurisdiction of Manitoba and agree that any dispute that arises between myself and Discount Meds of Canada, any of the represented pharmacies, its affiliates, related companies, subsidiaries, officers, directors, employees or agents shall be governed by the laws of the Province of Manitoba and the laws of Canada applicable to contracts formed in Manitoba, and I agree that the courts of the Province of Manitoba shall have sole and exclusive jurisdiction over any such dispute, including, but not limited to any claims of negligence and/or malpractice. Further, I agree that any and all agreements reached, or contracts formed, throughout the course of my relationship with Discount Meds of Canada shall be deemed to be made in Manitoba, and accordingly shall be governed by the laws of Manitoba, and the laws of Canada applicable to such contracts and agreements, and I acknowledge that I am benefiting from such laws by purchasing medication(s) from Canadian Pharmacies with Discount Drugs of Canada transmitting and storing the information. By agreeing to this document I confirm that I have read and understood these terms and that they are true and correct and I agree that the terms herein are binding on me and my heirs, assigns, successors and personal representatives.

7. HIPPAA Privacy Statement:

1. As required by law, any and all records are confidential and cannot be disclosed without my prior written authorization, except as provided by law. I may revoke my authorization at any time, except where information has already been released. I have the right to review any authorized disclosures.
2. I have the right to review my private health information and request amendments.
3. I have the right to request additional restrictions on the use of my private health information.
4. If I feel my privacy has been violated, I can contact the Discount Meds of Canada Licensee or the Secretary of Health and Human Services.

Date: _____Client's Name: (please print) _____

Client's Signature:_____

Patient Information

PLEASE FILL OUT ALL FIELDS COMPLETELY

_____ _____
Full Name Age

_____ _____
Address Birth Date (MM/DD/YYYY)

_____ _____ _____
City State Zip

_____ F_____ M_____ ____ft ____in. _____
E-mail Sex (check one) Height Weight

(_____)_____ (_____) _____
Phone (Home) Phone (other)

ALTERNATE SHIPPING ADDRESS (optional)

SHIP TO (check one): PRIMARY _____ ALTERNATE_____

_____ (_____)_____
Alternate Address Alternate Phone

_____ _____ _____
Alternate City Alternate State Alternate Zip

PAYMENT INFORMATION

(NOTE: PERSONAL CHECKS AND POSTAL MONEY ORDERS ARE NOT ACCEPTED)

VISA_____ MASTERCARD_____

Card Holder Name _____

Card Holder Address_____

Card Holder City_____ Card Holder State/Zip_____

Credit Card Number_____

3-Digit Security Code_____ Credit Card Expiry_____

I hereby authorize Discount Drugs of Canada's contracted pharmacy, to charge my credit card for the cost of medications ordered plus associated shipping costs.

_____ _____
Signature **Date** (Month/Day/Year)

MEDICATIONS YOU ARE CURRENTLY TAKING

Please list **any other** medications you are currently taking.

Medication & Strength Daily dosage (eg.1 tab daily)

_____ _____

_____ _____

How did you hear about us?_____

Please Note: Once purchased, medications may NOT be exchanged or returned. All Sales are FINAL.