



## **CUSTOMER AGREEMENT - Wisconsin Prescription Drug Resource Center Version**

No prescription(s) will be filled until a signed and dated copy of this document and a completed Patient Profile have been received by CanadaDrugs.com. These documents can be sent by fax to: **1-888-DRUGFAX**.

I, as the undersigned, being over the age of 21, hereby:

### **Disclosure and Representations**

Represent and confirm to **CanadaDrugs.com**, its affiliates, related companies, subsidiaries and parent company (hereinafter collectively referred to as “**CanadaDrugs**”) that:

1. The pharmaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state, or other jurisdiction in which I reside or where I sought treatment. I will not seek the delivery of medication that represents my first use of such medication.
2. The prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician.
3. I will use any medication obtained for me by **CanadaDrugs** strictly according to the instructions provided by the physician who prescribed the medication.
4. The pharmaceutical(s) will only be used as directed and only by the person for whom the pharmaceutical(s) were prescribed.
5. I can make my own medical decisions according to the law of the place where I reside.
6. The prescription(s) I am requesting **CanadaDrugs** to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to **CanadaDrugs**. I agree to immediately destroy all copies of my prescription(s) once it has been filled.
7. I am not seeking or relying on any medical information from **CanadaDrugs** and I have consulted a qualified physician licensed where I obtained the prescription within the last year.
8. 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 **CanadaDrugs**.
9. I understand that it is my responsibility to have regular physical examinations by my primary US licensed physician that is responsible for my care including all suggested testing to ensure that I have no medical problems which would constitute a contraindication to me taking the medications being prescribed.
10. I acknowledge that **CanadaDrugs’s** employees and agents have relied on the information and documentation that I am providing (including the Patient Profile) and I represent and confirm that I have fully disclosed all pertinent information and documentation to **CanadaDrugs**. I agree to notify **CanadaDrugs** of any changes to my physical or medical condition by providing an updated Patient Profile.

## Authorization and Consent

11. I hereby authorize and appoint **CanadaDrugs**, 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 in **Canada** that is the equivalent of the prescription that I sent to **CanadaDrugs**, 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 **CanadaDrugs** employees, agents and service providers including the Canadian physician being retained on my behalf, as required, for the limited purpose of obtaining the Canadian prescription. The authorizations and consents that I am providing to **CanadaDrugs** commence on the date I have signed this agreement and shall continue until I revoke them. I understand that I can revoke the consents and Authorizations I have granted to **CanadaDrugs** at any time.
12. I hereby specifically acknowledge that I am aware that **CanadaDrugs** will be transmitting my personal health information by electronic means (for example fax, secure internet) to its employees, agents, affiliates and service providers including the Canadian 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 **CanadaDrugs**, 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 **CanadaDrugs's** transmission of my personal health information by electronic means.
13. If I was directed to **CanadaDrugs's** services through an affiliate or intermediary (for example Pharmacy Benefit Manager, Health Management Organization, or other healthcare service provider), I hereby authorize **CanadaDrugs** 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.

It is my understanding that all such intermediaries will enter into Confidentiality Agreements where they agree to abide by the privacy policies of **CanadaDrugs** relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.
14. I authorize and appoint **CanadaDrugs** as my agent and attorney for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.
15. I authorize and appoint **CanadaDrugs** as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceutical(s) to me as if I had shipped the prescribed pharmaceutical(s) to my own address.
16. I acknowledge and agree that I initiated a consultation with **CanadaDrugs** and that **CanadaDrugs** is not located in the United States. I also acknowledge that the pharmacists working for **CanadaDrugs** and the physicians contracted by **CanadaDrugs** on my behalf are located and licensed to practice medicine or pharmacy in **Canada** and that all services that I receive from the Canadian pharmacy and the pharmacist are being received in **Canada**.

17. I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and **CanadaDrugs** shall be deemed to be made in the **Province of Manitoba, Canada and accordingly shall be governed by the laws of the Province of Manitoba and the laws of Canada applicable to such contracts and agreements.**
18. I agree that any dispute that arises between me and **CanadaDrugs**, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors 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.**

### **Purchase and Sale Terms**

19. **CanadaDrugs** will charge my credit card or will withdraw funds from my bank account through online checking for the following amounts:
  - a. the medication price and shipping (in **US Dollars**) as posted on the Wisconsin Prescription Drug Resource Center web site on the day **CanadaDrugs** receives my order, or the price and shipping (in **US Dollars**) as posted on the **CanadaDrugs** web site on the day **CanadaDrugs** receives my order, whichever is less; and
  - b. in the event my payment is not authorized, **CanadaDrugs** has the right to cancel my order and attempt to provide me with notice of such cancellation.
20. The pharmaceutical(s) will be packaged in child protected packaging, unless requested otherwise by me on the Patient Questionnaire.
21. That once purchased and shipped, no pharmaceutical product may be returned or exchanged.
22. **CanadaDrugs** 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.
23. **CanadaDrugs** does not provide its agency or attorney services as a substitute for healthcare or the advice of the customer's primary care physician.
24. **CanadaDrugs** 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.

I have read and understood the terms and conditions set out in this Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns to be bound by these terms and conditions.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Send completed **FORM** with your **PRESCRIPTION** and **PAYMENT** by toll free fax **1-888-DRUG-FAX** or mail to 24 Terracon Place, Winnipeg, Manitoba, Canada, R2J 4G7

**Questions: 1-800-CAN-DRUG**

## Patient Information

Male      /      /  
 Female      Birthdate (MM/DD/YY)

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

## Secondary Contact

Full Name of Secondary Contact \_\_\_\_\_

Relationship To You \_\_\_\_\_ Phone Number \_\_\_\_\_

## Your Physician

Primary Physician Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_ Fax Number \_\_\_\_\_

In order to offer you the highest possible level of confidentiality, representatives of CanadaDrugs.com will not share the details of this form with any person(s) not listed in the above section.

## Patient Counselling Information

All patients receiving prescriptions from a Manitoba pharmacy have the right to receive counselling from a licensed pharmacist.

Would you like a pharmacist to call you to provide patient counselling?  Yes  No

Do you have any known drug allergies?  Yes  No

If yes, please enter the drug(s) you are allergic to: \_\_\_\_\_

## Payment Options (Credit Card or Check)

**Credit Card** (We do not accept Discover, American Express, or Diners Club)

Credit Card Type:  Visa  Mastercard

Cardholder's Name \_\_\_\_\_

Cardholder's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Credit Card Expiry (MM/YY) \_\_\_\_\_

## Personal Checking Account (Check or EFT)

### TO PAY BY CHECK

Please make payment to **CanadaDrugs.com** and mail to:  
 24 Terracon Place  
 Winnipeg, Manitoba  
 Canada R2J 4G7

### FOR ELECTRONIC FUNDS TRANSFER (EFT)

Please send a voided check by fax to:  
 1-888-DRUG-FAX  
**Or mail a voided check to:**  
 24 Terracon Place  
 Winnipeg, Manitoba  
 Canada R2J 4G7

## Disclaimer

1. I have fully and accurately disclosed my personal and medical information and consent to its use by CanadaDrugs.com and its employees and agents ("CanadaDrugs.com"). I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.

2. I authorize CanadaDrugs.com 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 Canadian prescription for any prescription which I have sent CanadaDrugs.com; and (b) packaging my prescriptions and delivering them to me.

3. Title to my medications passes from CanadaDrugs.com to me when my medications leave CanadaDrugs.com's Canadian Pharmacy. All agreements reached or contracts formed with CanadaDrugs.com shall be deemed to be made in Manitoba, and the laws of the Province of Manitoba shall have sole and exclusive jurisdiction over any dispute arising between myself and CanadaDrugs.com, its affiliates, parent company, related companies, subsidiaries, officers and directors.

This agreement shall apply to every sale by CanadaDrugs.com to me and may not be altered unless in writing and signed by both CanadaDrugs.com and me.

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

## Medication You Are Currently Taking (Not Being Ordered)

MEDICATION	DOSAGE	FREQUENCY

## Medication You Are Ordering

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. Please remember that medications can only be ordered if accompanied with a copy of the original prescription from your doctor's office. If more space is need please include an extra page.

MEDICATION	STRENGTH	QTY	PRICE

**SHIPPING** (Shipping Fee \$9.95, or FREE on orders over \$99)

**TOTAL**

Would you like to receive a call to remind you of future refills?  Yes  No

## Referred By:

Full Name \_\_\_\_\_ Phone \_\_\_\_\_

MKT-WIS

Patient's Name (Print Clearly) \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_