

# Patient Form

Thank you for your interest in our prescription service. Customers can save from 20 - 85% on the cost of their medications by getting their prescriptions filled in Canada. Our prescription service allows customers to access the same medications that are available to them locally, but at much lower Canadian Prices.

If you need any information regarding the price of your prescription please contact us toll-free at 1.877.828.7555.

## Ordering Your Prescription:

- **Step 1:**  
Please complete the following medical questionnaire/medication order form. Any information you provide will be kept strictly confidential. You will only have to fill out this order form the first time you order from us.
- **Step 2:**  
Simply mail the information back to us, or to save mailing time, fax it toll-free to 1-866-783-4223.  
Mail to: Senior Rx Care  
PO Box 2581, Stn. Main 266 Graham  
Winnipeg, Manitoba, Canada  
R3C 4B3
- **Payment:**  
We accept VISA, MasterCard, checks and international money orders made out to Universal Drugstore Ltd. There is a short waiting period for banking authorization on personal checks.
- **Shipping:**  
The shipping fee is a flat rate of \$10.00 per package (not per drug, but per shipment) within the continental US.

## Please Be Advised:

- Government regulations limit the quantity of medication that you can order to a maximum of a 3-month supply. If your prescription allows refills, you can simply call us to order your refill.
- Most insurance companies will accept receipts issued from a Canadian pharmacy, however, patients with drug insurance plans should contact their insurance company first before ordering.
- Our service is open to anyone who is a Mature Voices Minnesota member. Please feel free to give our toll-free number or website address to friends and family, or to make copies of our order form for other people.
- On occasion, shipping delays can occur as a result of action by US customs and the US FDA. They can hold shipments for up to 30 days. Such delays are beyond our control. Please ensure you have enough medication on hand for possible delays.

## Contact Us:

Toll-Free Phone: 1-877-828-7555  
Toll-Free Fax: 1-866-783-4223  
Email: [info@seniorrxcare.com](mailto:info@seniorrxcare.com)

## Patient Information

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

Patient Name \_\_\_\_\_

Shipping Address \_\_\_\_\_

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

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

Email Address \_\_\_\_\_

## Secondary Contact

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

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

### Your Physician

Primary Physician's Name \_\_\_\_\_

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

## Medication Being Ordered (Attach additional sheet if required)

Important (Please read carefully): In the spaces provided below please write the medications that you would like us to fill for you at this time. Any medications not written here, but which you have sent a prescription for, will not be filled at this time. These medications will be filed on our computer and can be filled at a later date.

Brand Only	Generics Permitted	Requested Medications	Strength	QTY	Price
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				

Please note that we will fill your prescription where applicable in the manufacturer's sealed containers. For example, if your prescription calls for 90 tablets, but the manufacturer supplies bottles of 100, we will fill for 100 tablets.

Add \$10.00 Shipping & Handling to U.S.  
(Trackable Insured Shipping via Express Post)

**\$10.00**

(Payment in U.S. Funds) Total Enclosed

## Current Medications

This is for our records only and will be kept confidential. Listing other medications that you are currently taking will help us create a more complete medical history for you.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please enter any known drug allergies.

\_\_\_\_\_

\_\_\_\_\_

## Patient Counseling

Please choose one of the following 3 options

A pharmacist may contact you with any questions regarding your medication

I understand my medications and do not need to speak to a pharmacist or receive information sheets.

I do require medication information sheet only.

I would like to speak to a pharmacist about my medications.

If you require patient counseling as indicated above, how would you like to be contacted?

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

## • Method of Payment

Please indicate your method of payment and fill out the requested details:

- International Money Order  
 Pre-Authorized Payment

- MasterCard Debit     VISA Debit     Personal Check  
 MasterCard         VISA

### Credit Card Payment

Credit Card #:

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Exp. Date: / /

Name on Card: \_\_\_\_\_

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

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

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

### Pre-Authorized Payment

Contributor's Name on Account: \_\_\_\_\_

Bank Account #: \_\_\_\_\_

Transit #: \_\_\_\_\_

Name and Address of Bank or Trust Company: \_\_\_\_\_

I hereby authorize my account to be debited by Senior Rx Care Ltd. via Pre-Authorized Payment, outside of the current CPA standards.

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

Signature of Authorization: \_\_\_\_\_

Upon placing your order with Senior Rx Care, confirmation will be provided by the Senior Rx Care Confirmation Department. Your Pre-Authorized Payment debit will be processed within a 24 hour period for the amount that will be confirmed.

To ensure accuracy, a sample check, marked "VOID" must accompany this form. Notification to cancel this payment method or change any details of this payment must be received in writing to Senior Rx Care Ltd.

CPA - Canadian Payment Standards require notification of a 10 day period before debiting an account. This authorization will shorten this notification period to 24 hours.

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I certify that I have read and understood the Authorization and Release and that the information provided by me is accurate and true.

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

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

/ /  
Date \_\_\_\_\_

## Medical History

Please list present illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc. (attach separate sheet if required):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate any known allergies you may have:

\_\_\_\_\_

I the Undersigned hereby represent and confirm to Senior Rx Care, Universal Drugstore Ltd. (hereinafter "The Providers") and to each of its affiliates, associates, Fulfillment Centers (defined below), related companies, subsidiaries, parent company, and each of their respective directors, officers, shareholders, employees, contractors, subcontractors, successors and assigns that:

1. I am delivering this Agreement to The Providers for the purpose of placing an order for certain medications ("Ordered Products") on the terms and conditions set out herein.
2. I am of the age of majority in the jurisdiction in which I ordinarily reside (the "Place of Residence") and am not restricted from making my own medical decisions under the laws of my Place of Residence.
3. The Ordered Products were prescribed to me by a duly qualified medical practitioner ("My Doctor") in my Place of Residence, or where I sought treatment and no laws have been violated in obtaining the prescription ("My Prescription") for the Ordered Products.
4. The Ordered Products will not be used in any way whatsoever, except as prescribed by My Doctor, and as such will be used only by me.
5. My Prescription has not been altered in any way, nor has it been filled prior to submission to The Providers. I agree to immediately destroy all copies of My Prescription once it has been filled.
6. It is my responsibility to have regular physical examinations by My Doctor that is responsible for my care including all suggested testing, to ensure that I have no medical conditions or problems which could cause adverse effects to me by taking the Ordered Products. I will immediately contact My Doctor in the event I suffer any unexpected side effects from any of the Ordered Products.
7. UDS has and will continue to rely on the information and documentation that I am providing to them, and I represent and confirm that I have fully and truthfully disclosed all pertinent information and documentation to The Providers. I agree to notify The Providers of any changes to my physical or medical condition.
8. Participating consumers acknowledge and agree that MVM does not provide any clinical or dispensing services and that it has no liability with respect to the appropriateness, suitability, strength or dosages of the pharmaceuticals prescribed or dispensed for you including, without limiting the generality of he above, any dispensing errors or side-effects or ill effects whatsoever of any kind or nature.
9. Participating consumers also acknowledge and agree that he/she did not rely on MVM with respect to the dispensing of the pharmaceuticals prescribed other than to forward the prescription to the dispensing pharmacy. Any disputes regarding the dispensing, shipping or other matters relating to the prescription shall be between the undersigned and the Canadian pharmacy whose name and address appears on the prescription.
10. Confidentiality And Privacy - For verification, administration and eligibility purposes for using this MVM Canadian drug importation program, you agree that SRC/UDS will provide your name, address, phone number, email address and Federation membership number to the MVM. No personal medical information will be included without your specific permission.

I hereby authorize and appoint The Providers as my agents and attorneys for the limited purpose of taking all steps and signing all documents on my behalf which are necessary to permit the delivery of the Ordered Products to me, 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 Doctor or pharmacist, and disclosing that personal health information to The

Providers employees, agents, contractors, subcontractors, affiliates, service providers, and fulfillment pharmacies, including without limitation any physicians, any Fulfillment Pharmacies, and any pharmacist being engaged on my behalf (collectively "My Agents"), as required, for the limited purpose of obtaining my Ordered Products. Neither The Providers nor My Agents provide their agency or attorney services as a substitute for healthcare or the advice of My Doctor or primary care physician. I hereby specifically acknowledge and consent that The Providers will be transmitting my personal health information by electronic (for example fax, or secure internet) or verbal means to My Agents. The Providers, as a custodian of my personal health information, will take all appropriate precautions to protect my personal health information from disclosure or improper use. The Providers may, as my agent and under my direction, select a licensed pharmacy or fulfillment center in Canada or other countries (the "Fulfillment Pharmacies") to dispense my Ordered Products. My Ordered Products will be shipped directly to me by (and I am purchasing my Ordered Products from) the Fulfillment Pharmacies. I specifically acknowledge and agree that any and all agreements reached or contracts formed throughout the course of my purchase of my Ordered Products, and also in respect to any dispute that may arise between me and The Providers or My Agents, shall: A. in respect of any Ordered Products that are dispensed by The Providers, in the Province of Manitoba, Canada, shall accordingly be governed by the laws of the Province of Manitoba, Canada. B. in respect of any Ordered products that are dispensed by any Fulfillment Pharmacies in their respective jurisdiction, shall accordingly be governed by the laws of that respective jurisdiction. The providers reserve the right to not accept any order cancellations after 48 hrs. of receiving your order. Cancelled orders may be subject to a cancellation fee. As per the pharmaceutical act of Manitoba Regulation 23(1) "A pharmacist shall not accept for return to inventory any drug that has been previously dispensed". The Ordered Products may not be returned for a refund or an exchange. If the Undersigned is placing the order on behalf of someone else, the Undersigned represents that they have all necessary consent, permission and authorization to do so on behalf of that person and their heirs, agents and successors and the person they represent agrees to all of the above terms and conditions, understands all of the above conditions and has had an adequate opportunity to consult any advisors necessary, whether medical, legal or otherwise. By signing this document I confirm that I have read and understood these terms and conditions and that these terms and conditions will apply to and govern any orders by me of medications from UDS, unless I specifically indicate otherwise at the time of ordering such medications. Without limiting the foregoing, each authorization and consent provided by me in this agreement will continue until I cancel such authorization or consent (which I can do at any time).

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

Date \_\_\_\_\_

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

Patient's Name (Please Print)

Phone Number

Patient's Signature

Date

• YOUR PRESCRIPTIONS – Attach Here

(Please ensure that we can see the entire prescription)  
Please use additional pieces of paper if you cannot fit all  
of your prescriptions in the designated area