

Discount Drugs of Canada

ENROLLMENT INSTRUCTIONS

Many thanks for becoming a member of Discount Drugs of Canada.

We offer the highest quality service and fast delivery of your Brand Name and Generic Drugs. If you do not wish Generics please be sure that your prescription says: brand name only or no generics and also circle the correct type on the enrollment forms which are attached!

- ★ NO FEES OF ANY KIND
- ★ \$10.99 SHIPPING FOR THE FAMILY
- ★ DELIVERY IN 30 DAYS OR LESS
- ★ EXCELLENT CUSTOMER SERVICE
- ★ THE BEST PRICES!

Toll Free Refill Hotline:
877-488-0638

Please complete these enrollment forms, also sign and date where indicated.

Return them to our office along with your valid prescriptions.

They may also be faxed or mailed to us at:

P.O. Box 1532 Venice, FL 34284-1532

ph: 1 877 488 0638 (toll free) | fax: 941 488 8065

1 877 488 0638

www.ddofc.com - www.ddfromc.com

Discount Drugs of Canada

"Information and Services Provider"

In consideration of Discount Drugs 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 Drugs is NOT A PHARMACY and I understand that DDOC'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 DDOC'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 Drugs 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 Drugs 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 Drugs 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 Drugs 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 Drugs 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 Drugs 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. HIPAA 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 Drugs 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 _____

E-mail F _____ M _____ ____ft ____in. Weight _____

Sex (check one) Height _____

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

ALTERNATE SHIPPING ADDRESS (optional)

SHIP TO (check one): PRIMARY _____ ALTERNATE _____

Alternate Address (_____) _____
Alternate Phone

Alternate City Alternate State _____ Alternate Zip _____

PHYSICIAN INFORMATION

Primary Physician Name (_____) _____
Phone

Name of Clinic / Doctors Office (_____) _____
Fax Number

Address City _____ State _____ 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 _____

Credit Card Expiry _____ Card Holder Country _____

Unless otherwise notified in writing, I hereby authorize Discount Drugs of Canada's contracted pharmacy, to charge my credit card for the cost of all present and future medications ordered plus all associated shipping costs.

Signature _____
Date (Month/Day/Year)

How did you hear about us? _____

Medical Questionnaire

Patient Medical History

- 1) High blood pressure Yes ___ No ___
- 2) Heart or artery disease including atherosclerosis, angina, palpitation, heart failure or history of heart attack Yes ___ No ___
- 3) Liver disease Yes ___ No ___
- 4) Kidney disease Yes ___ No ___
- 5) Cancer Yes ___ No ___
- 6) Immune disorders Yes ___ No ___
- 7) Blood disorders Yes ___ No ___
- 8) Diabetes, thyroid, or other endocrine disorder, including insulin resistance Yes ___ No ___
- 9) Cholesterol disorder Yes ___ No ___
- 10) Smoker Yes ___ No ___
- 11) Asthma or emphysema Yes ___ No ___
- 12) Neurological disorders Yes ___ No ___
- 13) Emotional disorders Yes ___ No ___
- 14) Poor wound healing Yes ___ No ___

- 15) Rheumatoid arthritis, lupus, or connective tissue diseases Yes ___ No ___
- 16) Any known nutrition deficiency including minerals and electrolytes Yes ___ No ___
- 17) Edema (fluid retention) Yes ___ No ___
- 18) Glaucoma Yes ___ No ___
- 19) Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome Yes ___ No ___
- 20) Surgery Yes ___ No ___
- 21) Chemical dependency Yes ___ No ___
- 22) Other illness not yet noted. Yes ___ No ___

***Please indicate any known drug allergies you may have:**

CURRENT MEDICATIONS

Please list all medications you are currently taking and the condition for which they are prescribed.

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

MEDICATIONS BEING ORDERED TODAY

Please list all medications you are currently taking and the condition for which they are prescribed.

Medication	Strength	Qty	Generic	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

Please note that once purchased, medications may NOT be exchanged or returned.
All sales are FINAL.