

SAVE ON MEDS

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THESE FORMS NEED ONLY BE COMPLETED ONCE
CALL IF YOU NEED ASSISTANCE COMPLETING THESE FORMS
New Customer Enrollment Form

- MAIL or FAX forms with your Prescription.
- Original Prescription must be mailed in also for our records.
- Order is placed when we receive all pages AND your prescription.

RX Group Number from Membership Card: _____
Doctors RX Choice Number: _____

Your Contact Information

Today's Date: _____ Date of Birth: _____

Male: Female:

Name: _____

Street Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____
(Order Confirmation: Put marty@saveonmeds.biz on your Buddy List.)

Method of Payment

Visa MasterCard American Express

Cardholder's Name: _____
(As shown on card)

Credit Card #: _____

Expiration Date: _____

Cardholder's Signature: _____

Date Signed: _____

SAVE ON MEDS

Your Prescription Order

Have you had a physical examination by a qualified Medical Doctor in the last 12 months?

Yes No

Have you had this medication(s) before? Yes No

Substitute generic for name brand when possible? Yes No

Medication Name	Strength	Quantity	Price Estimate

**Prices subject to change without notice. Check prices online, call or e-mail us.*

- **Shipping Fee - \$6.00 from US and \$15.00 from overseas**
- **Husbands and Wives can ship together**

List All Medical Conditions Being Treated By A Healthcare Provider:

Drug Allergies:

1. _____
2. _____

3. _____
4. _____

Height: _____

Weight: _____

Your Prescribing Physician:

Doctor's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Fax: _____

- **MAIL or FAX these forms and your prescription.**
- **Use any blank paper for the names of other doctors**
- **Please proofread order. We cannot accept or credit for returns.**

SAVE ON MEDS

PATIENT RELEASE/DISCLAIMER

A. Personal Information

- 1) I hereby state that I am at least eighteen years of age and I am fully competent to make my own health care decisions.
- 2) I understand that it would be a violation of the law to falsify any information.
- 3) I understand that it is my responsibility to have regular physical examinations by the U.S. licensed physician whose care I am under including all suggested testing by said physician to ensure I have no medical problems, which would constitute a contradiction to me taking the medications being prescribed for me.

B. Medical Information

- 1) I will only use the medication as prescribed.
- 2) I will not allow anyone else to use my medication.
- 3) I acknowledge I may not return any medication dispensed to me.
- 4) I am aware of the potential side effects and/or problems associated with prescription medications.
- 5) I am not seeking medical advice or treatment of any kind whatsoever and I am dealing with SAVE ON MEDS and its pharmacies for the sole purpose of obtaining medication.
- 6) If necessary, SAVE ON MEDS or one of their pharmacies or one of its authorized representatives may contact me or, my physician for more information. I hereby give permission to my physician to release my medical files and medical reports as needed to obtain sufficient information for the purpose of prescribing my medications.
- 7) I understand that this service should not be considered a substitute for a health care provider. I understand that this service is not in any way intended for the diagnosis of a medical condition. I understand that SAVE ON MEDS, or any of its pharmacies, or its authorized representatives, will not make any medical diagnoses and that the SAVE ON MEDS web site should not be used as a substitute for professional medical advice.
- 8) I will direct all questions to my own health care provider. I will consult my own physician before taking any new drug or changing my daily health regimen.

C. Medication

- 1) I hereby acknowledge that the prescription I wish to obtain was originally prescribed by my personal doctor.
- 2) I agree that should I suffer any adverse effects while taking these prescribed medications, I will immediately contact my licensed physician whose care I am under.
- 3) Any and all questions that I have about my prescription medications and their associated risks have been answered to my satisfaction.
- 4) Should I come under the care of another physician, I will inform him or her of any and all medications I am taking which have been prescribed.
- 5) I understand that SAVE ON MEDS and its pharmacies will only verify medications that my licensed physician (whose care I am under) has already prescribed to me.
- 6) I understand that SAVE ON MEDS and its pharmacies reserve the right to refuse to fill any prescription order that they deem invalid or questionable.
- 7) I understand that prescription prices appearing on the web site are subject to change without notice.

D. The Release

- 1) I release and discharge SAVE ON MEDS and its pharmacies, including all of their employees and contractors including pharmacists, pharmacy technicians, physicians, nurses, and receptionists from any and all liability whatsoever associated or connected to my medical consultation and the use of any and all of the medications prescribed to me and any adverse effects I may suffer from these medications.
- 2) I understand the risks of taking medication and I understand that all of the possible risks and/or complications that may occur may never have been recorded before.
- 3) By signing this Patient Release/Disclaimer, I agree to release from liability and hold harmless the physicians, affiliates, directors, officers, employees, representatives, and independent contractors (SAVE ON MEDS) from all causes of action, suits, penalties, liens, judgments, liabilities, obligations, losses, actual or consequential damages and actual or threatened claims which may arise at any time by reason of relating to, arising directly or indirectly out of any matter whatsoever related to the prescribing or dispensing of my prescription medications.
- 4) I understand that any options, advice, statements, services, offers, or other information expressed or made available by third parties (including merchants and licensors) are those of the respective authors or distributors of such content.

- 5) I understand that SAVE ON MEDS and its pharmacies reserve the right to change this Patient Release/Disclaimer and the medical consultation form at any time.

E. Disputes

- 1) I agree to the jurisdiction of the Province where the managing pharmacy maintains its offices, meaning that any dispute that arises between the managing pharmacy and me will be governed by the laws of that Province and any applicable federal laws of Canada; and
- 2) If any dispute does arise between any of the pharmacies and me about rights or liabilities arising from the purchase of my medication that cannot be resolved on the basis of both sides acting reasonably, then such dispute shall be referred to arbitration in the Province where the managing pharmacy maintains its place of business.

This agreement represents the complete and entire agreement between SAVE ON MEDS, its participating pharmacies and me. I have read and understood the above-referenced "Patient Release/Disclaimer". I declare that I understand all the terms and conditions herein.

My Signature: _____

Date Signed: _____

Print Name: _____