



PRESCRIPTION DRUG ORDER FORM

Need help?

You can order by calling our toll free number between 9am-5pm PST (12pm-8pm EST) from Monday and Friday. Our helpful staff will walk you through the steps, setup an account for you and complete your order. You may also speak to our pharmacist at any time.

Toll Free Help Line: 1-877-743-7847

E-mail: info@smartmedcare.com

What's Involved

- Step 1 Carefully read and sign the Patient Authorization and Release Agreement.
- Step 2 Carefully complete and sign the Patient Information and Order Form.
- Step 3 Mail or Fax the two forms along with your prescription to us.
- Step 4 Once we receive your completed information, payment and prescription, we will contact you regarding the status of your order.

How and Where to Send the Documents

Once you have completed and signed the attached forms you can mail them or fax them to us. **BY FAX IS FASTER.**

MAIL TO:

Smartmedcare.com
4241 Fraser Street
Vancouver, B.C.
Canada V5V 4G1

OR

FAX TO:

1-877-743-7839

Please note that we cannot ship your prescription items prior to receiving these forms with the accompanying prescription from your doctor.

Return Policy

Prescriptions are not returnable. For more information please visit the help section of Smartmedcare.com.

Your Credit Card Will Be Billed

- a) Drug costs as quoted on our website or by our pharmacy staff.
- b) Shipping costs as quoted on our website or by our pharmacy staff.

**Please keep this page for your records.
YOU DO NOT NEED TO FAX OR MAIL THIS PAGE TO US.**

PATIENT AUTHORIZATION AND RELEASE AGREEMENT (2 pages)

Need help?

Toll Free Help Line: 1-877-743-7847

E-mail: info@smartmedcare.com

Send to Us By:

Mail or Fax

As a precondition to Metropolitan Pharmacy LTD (Canada), "North Fraser Drugs" and "Smartmedcare.com" being able to fill my prescription or non prescription order, I acknowledge and agree as follows:

1. I am twenty one years of age or older, or the parent or legal guardian of a patient who is under the age of twenty one years, and that I am fully competent to make my own health care decisions and for those of people under my care.
2. I am dealing with the website Smartmedcare.com and its licensed Canadian pharmacy Metropolitan Pharmacy LTD "North Fraser Drugs" for the SOLE PURPOSE OF OBTAINING PRESCRIPTION MEDICATION AT A LOWER PRICE THAN IN THE UNITED STATES OF AMERICA.
3. I AM NOT SEEKING MEDICAL ADVICE OR TREATMENT of any kind whatsoever in dealing with Smartmedcare.com and its physicians, pharmacists, employees, officers, agents and all others acting through or for it.
4. Neither Smartmedcare.com, nor any of its physicians, pharmacists, employees, officers, agents and all others acting through or for it, or anyone that is acting on its behalf, is providing medical advice, professional advice, treatment advice or treatment of any kind whatsoever to me.
5. I confirm that the pharmaceutical(s) to be delivered to me, or to a person in my care, were legally prescribed by my American Doctor licensed to practice medicine in the United States of America and that the prescription(s) for the pharmaceuticals were lawfully obtained from that American Doctor and that the pharmaceutical(s) will be used only as directed and only by the person for whom the pharmaceutical was prescribed.
6. I understand that Smartmedcare.com will only fill medications that my American Doctor has already prescribed to me.
7. I understand that it is my responsibility to have my American Doctor conduct regular physical examinations of me, including any and all suggested testing by my American Doctor to ensure that I have no medical problems which would constitute a contradiction to me taking medications prescribed for me by my American Doctor.
8. I understand that Smartmedcare.com is required to have a licensed Canadian Physician (the "Canadian Physician") review my medical information for the purposes of submitting the prescription to a Canadian pharmacy. By reviewing my medical information, the Canadian Physician IS NOT RENDERING OR PROVIDING ANY SERVICE OR ADVICE to me whatsoever. This review IS NOT AN ASSESSMENT OF MY CONDITION NOR OF THE APPROPRIATENESS OF THE MEDICATION. My American Doctor in the United States of America who prepared the original prescription has conducted this assessment.
9. I understand that Smartmedcare.com is located in the Country of Canada and that the Canadian physicians and pharmacists working for Smartmedcare.com are located and licensed to practice medicine and pharmacy, respectively, in Canada only and any prescription, if any, that I am receiving from such physicians and pharmacists shall be deemed to be received by me in Canada.
10. I AGREE THAT THE CANADIAN PHYSICIAN SHALL NOT BE LIABLE FOR ANY LIABILITY, CLAIM, LOSS, DAMAGE OR EXPENSE OF ANY KIND OR NATURE CAUSED DIRECTLY OR INDIRECTLY BY ANY INADEQUACY, DEFICIENCY OR UNSUITABILITY OF THE PRESCRIPTION ISSUED BY THE CANADIAN PHYSICIAN OR THE INADEQUACY, DEFICIENCY OR UNSUITABILITY OF THE CANADIAN PHYSICIAN'S REVIEW OF MY MEDICAL INFORMATION. IN NO EVENT WILL THE CANADIAN PHYSICIAN BE LIABLE OR RESPONSIBLE FOR ANY DAMAGES WHATSOEVER, INCLUDING, DIRECT, INDIRECT, PUNITIVE, SPECIAL OR CONSEQUENTIAL DAMAGES, EVEN IF ADVISED OF THE POSSIBILITY THEREOF.
11. I hereby waive any requirement of the Canadian Physician under the laws of Canada, the United States or any other country to conduct a physical examination.

12. I understand that Smartmedcare.com recommends regular physician examinations with my American Doctor whose care I am under and who prescribed my medications and I certify that I have had a physical examination by my American Doctor within the last 12 months from the date hereof. I further stipulate that I will continue to have my medical condition and medications obtained in Canada monitored by my American Doctor.

13. I hereby give permission to my American Doctor to release any and all medical information and data whatsoever which Smartmedcare.com may request and that any information provided to Smartmedcare.com may be seen by its physicians, pharmacists, employees, agents and contractors and that this information will constitute a medical record.

14. I agree to truthfully and to the best of my knowledge answer all of the questions on my medical questionnaire and understand that it would be a violation of law to falsify any information on my medical questionnaire or other medical records for the purposes of obtaining prescription medication. Furthermore, I understand that I will ENDANGER MY LIFE should I falsify intentionally or unintentionally such information.

15. I agree that if I fail in any way to fully furnish my complete and accurate medical history or I become aware of any changes in my physical or medical condition in the future and I fail to notify my American doctor and Smartmedcare.com of such failure, that I AM SOLELY RESPONSIBLE FOR ANY ADVERSE EFFECTS THAT I MAY SUFFER FROM TAKING OR CONTINUING TO TAKE SUCH PRESCRIBED MEDICATIONS.

16. I agree that should I suffer any adverse effects while taking any prescription medication that I will immediately contact my American Doctor and that in the event I come under the care of another American Doctor, I will inform him or her of any and all medications that I have been prescribed including those that were purchased from Smartmedcare.com.

17. I am fully aware of the potential side effects and/or problems associated with my prescription medications. If I am not fully aware, I will not order the drugs from Smartmedcare.com.

18. I understand that NO NEW PRESCRIPTIONS CAN BE FILLED through Smartmedcare.com. I must have already been taking the prescribed medication for a minimum period of 30 days immediately prior to the date that I submit my prescription through Smartmedcare.com for filling.

19. I understand that no controlled medications, narcotics, tranquilizers, or other medications that the Canadian Physician may decide is inappropriate, will be filled.

20. In consideration of Smartmedcare.com selling and or accepting this prescription from/to me, I agree not to sue Smartmedcare.com, Metropolitan Pharmacy LTD "North Fraser Drugs" ,its physicians, pharmacists, employees, owners, officers, agents and all others acting through or for it, and release Smartmedcare.com and Metropolitan Pharmacy LTD "North Fraser Drugs", its physicians, pharmacists, employees, owners, officers, agents and all others acting through or for it, from all legal liability for any problems associated with the delivery or taking of the prescription.

21. I agree that the relationship between and the resolution of any and all disputes arising between me and Smartmedcare.com/Metropolitan Pharmacy "North Fraser Drugs", its physicians, employees, officers, agents and all others acting through or for it, shall be governed by and construed in accordance with the laws of the Province of British Columbia, Canada.

22. I agree that the Courts of the Province of British Columbia shall have jurisdiction to entertain any complaints, demands, claims or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the signing of this prescription, and I hereby agree that I submit irrevocably to the exclusive jurisdiction of the Courts of the Province of British Columbia.

I have read and understand the above "Patient Authorization and Release Form" including all paragraphs numbered 1 through 22 contained on pages numbered 1 and 2 and agree to each of the foregoing terms.

Patient's Name (print clearly)

**Guardian's Name if applicable
(print clearly)**

**Patient's or Guardian's
Signature**

Date (Day/Month/Year)

PATIENT INFORMATION AND ORDER FORM (3 pages)

Need help?

Toll Free Help Line: 1-877-743-7847
E-mail: info@smartmedcare.com

Send to Us By:

Mail or Fax

A) Patient Information

Last Name: _____ First Name: _____
Date of Birth: _____ Gender (M / F): _____
Height: _____ Weight: _____
Telephone: (_____) _____ Alternate Telephone: (_____) _____
Best Time to Call: _____ E-mail: _____
Street Address: _____
City: _____ State: _____
ZIP Code: _____
Occupation: _____

B) Primary American Doctor Information

Last Name: _____ First Name: _____
Street Address: _____
City: _____ State: _____
ZIP Code: _____ Telephone: (_____) _____

C) Overview

i) Do you exercise regularly? (Y / N) _____

ii) Please indicate any known drug allergies you may have in the box below:

iii) It is mandatory to have had a physical examination in the last 12 months. Have you had a physical examination in the last 12 months? (Y / N) _____

Patient's Name (print clearly)

Patient's or Guardian's Signature

D) Medications Being Ordered

Please list the medication(s) you are ordering:

<u>Quantity</u>	<u>Medication</u>		<u>Illness / Diagnosis</u>
_____	_____	for	_____
_____	_____	for	_____
_____	_____	for	_____
_____	_____	for	_____
_____	_____	for	_____

E) Current Medications

Please list all other medications you are currently using, including the dosage and frequency.

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>		<u>Illness / Diagnosis</u>
_____	_____	_____	for	_____
_____	_____	_____	for	_____
_____	_____	_____	for	_____
_____	_____	_____	for	_____
_____	_____	_____	for	_____

F) Personal Medical History

Blood Disorders	Y ___	N ___	Lipid or Cholesterol deficiency	Y ___	N ___
Cancer	Y ___	N ___	Heart disease	Y ___	N ___
Immune disorders	Y ___	N ___	Renal or Kidney disease	Y ___	N ___
Poor wound healing	Y ___	N ___	Liver disease	Y ___	N ___
Neurological disorders	Y ___	N ___	Orthopedic or muscle disorders	Y ___	N ___
Nutritional deficiency	Y ___	N ___	Emotional disorders	Y ___	N ___
Diabetes, Thyroid or other Endocrine disorders	Y ___	N ___	Glaucoma	Y ___	N ___

If you answered yes to any of the above questions please explain in the box below (i.e. duration of illness, any treatment or surgery received, etc).

Patient's Name (print clearly)

Patient's or Guardian's Signature

G) Order Details

In which of the following container formats would you like to receive your medication?

- The original manufacturer's container - which may not be childproof.
- Our pharmacy container - which is childproof but is not in its original container.

Would you like our pharmacist to call you with information regarding the medication?

- Yes
- No

H) Credit Card Information and Authorization

Name On Credit Card: _____

Street Address: _____

City: _____ State: _____ ZIP : _____

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Diners Club <input type="checkbox"/> JCB	Credit Card Number: _____ Expiration Date: _____ / _____ <div style="display: flex; justify-content: space-around; width: 100%;"> (MM) (YY) </div>
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I, _____ the cardholder hereby authorize Metropolitan Pharmacy Ltd (Canada) to charge my credit card used to make a purchase at Smartmedcare.com. I understand that my credit card charge will appear as Metropolitan Pharmacy Ltd on my statement. I also understand that it may take 4 weeks to receive my purchase at Smartmedcare.com

I have read, understood and completed the above "Patient Information and Order Form " including all sections A through H contained on pages numbered 3 through 5. I understand that it is my obligation to complete the aforementioned information accurately and any failure to do so intentionally or unintentionally will have adverse affects.

Patient's Name (print clearly)

Guardian's Name if applicable (print clearly)

Patient's or Guardian's Signature

Date (Day/Month/Year)

Please note that omitting any of the information needed or steps requested could result in delays in the processing of your order. Please check that you completed all steps as instructed before submitting your information to us.

ATTACH PRESCRIPTIONS

Need help?

Toll Free Help Line: 1-877-743-7847

E-mail: info@smartmedcare.com

Send to Us By:

Mail or Fax

ATTACH PRESCRIPTION HERE

Please ensure that we can see the entire prescription.

**Please use one page per prescription
Print extra copies of this page if you have additional prescriptions**

Office Use Only

Order Number: _____

Date: _____

Ref: _____

Total Amount of Order: _____