

US Resident Prescription Service



To Register, Carefully Follow These 3 Easy Steps!

1. Registration Form

Fill out the attached Registration Form in Full. This **must** include: your Physicians name, complete contact Information, your preferred method of payment and current shipping address. Don't forget to sign the patient disclaimer!

2. Patient Customs Statement

Fill out the top section and leave the bottom section blank and ensure that you include information for **all** of your current Doctors.

3. Prescriptions

Maximize your savings, ask your Doctor to write you a 3 month supply with 3 refills. To speed up the processing of your order, your doctor can fax prescriptions to **1-877-948-0464** directly from their office. Faxed prescriptions can **only** be accepted when faxed directly from your Doctors office.

Alternatively, you may send any **original** prescriptions along with all completed paperwork to us through regular post (2x43 cent stamps) or courier and they will be processed immediately upon their arrival.

Registration Checklist

To ensure there are no delays in processing your order, please ensure that **all** of the following necessary paperwork is sent together.

- Registration Form - Completed
- Patient Custom's Statement - Signed
- Patient Disclaimer - Signed
- Medical Information - Completed (See Registration Form)
- 3 month Prescription From Your Doctor

Orders that do not contain all of the above paper work will experience a delay in processing until all paperwork is complete

Additional Ordering Information

- Shipping plus insurance ranges from \$9.00- \$20.00 dependant upon the value of your order
- Your Credit Card may be charged in Canadian Dollars. If you are using our E-cheque debit service , please fill-out the Authorization for E-cheque Debit Forms
- Certain medications are not available from Canada or unsuitable for shipping across borders



OCP Certificate of Accreditation

www.Adv-Care.com rated a Five Check Online Pharmacy - Highest Rating

Click to verify

ADV-CARE Pharmacy 195 Riviera Dr. Unit 2, Markham, Ont. L3R 5J6
Telephone: (905) 948-1991 Toll-Free:(888) 471-4721 Fax: (877) 948-0464

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Patient Customs Statement



The undersigned hereby acknowledges, confirms and certifies that the enclosed medications are imported to the USA solely for personal use for a period not exceeding 3 months.

These medications are prescribed by the following Doctor(s):

Primary Doctor: _____ License # _____

Other Doctor: _____ License # _____

Other Doctor: _____ License # _____

(If you do not know your Doctor's license number, the pharmacy will attempt to acquire it.)

The above-mentioned Doctor(s) is/are responsible for my treatment with regard to the enclosed medication(s); a copy of my prescription(s) is available.

Patient Name: _____

Address: _____

Phone: _____

Signature: _____

FOR PHARMACY USE ONLY

Authorized by Doctor: _____

Who holds a Ontario License Number: _____

Phone Number: _____



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Registration Form



Personal Information:				
Last Name	First Name	Group	Birth Date	Gender
				<input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Information:				
Address	City	State	Zip	Country
Phone	Fax	Email		
Medical Information:				
Medications Currently Prescribed				
Allergies: <input type="checkbox"/> No, no known allergies <input type="checkbox"/> Yes, please specify:				
Allergy (drug), reaction?				
Medical Conditions (please check)				
<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Hysterectomy	
Other Medical Conditions, Please Specify:				
RX Refill Options:				
		<input type="checkbox"/> Refill by Email	<input type="checkbox"/> Refill by Phone	
Accept Generic Substitute:				
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Your Doctor Information:				
Dr. Last Name	Dr. First Name	Phone	Fax	
Dr. Address	City	State	Zip	
Shipping Information: (required if different than contact information above)				
Shipping Address	City	State	Zip	Country
Shipping Insurance is mandatory for orders above \$100 Canadian Dollars				
Credit Card Information:				
Card Holder Name (on card)	Card Number	Expiration (MM/YY)		
Method of Payment (check only one):				
<input type="checkbox"/> Visa	<input type="checkbox"/> Mastercard	<input type="checkbox"/> Discover	<input type="checkbox"/> E-check	

By signing below, I authorize ADV-CARE Pharmacy Inc. to check the accuracy of the personal information I have provided. I understand that in order to verify my personal information, Adv -Care Pharmacy Inc. may disclose my personal information to the third parties and such third parties may provide verification of such personal information to Adv -Care Pharmacy Inc. from information they have previously collected about me. I also, authorize ADV-CARE Pharmacy to transfer any my prescriptions to my local pharmacy or a pharmacy of their choice, I also acknowledge that due to the nature of this business, all orders received are considered Final and no medications can be returned once shipped.

Signature: _____

Date: _____

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Patient Disclaimer



I hereby release ADV -Care Pharmacy Inc., including all of its employees, agents, representatives and contractors including physicians, pharmacists, pharmacy technicians, nurses, and receptionists ("ADV -Care") from any and all liability whatsoever associated with or connected to my use of this website, including consultation, the late delivery, non-delivery or missed delivery, and the use of any or all the medications dispensed to me or services provided by ADV -Care and any adverse effects I may suffer from these medications dispensed by ADV -Care. I hereby state that I am at least eighteen (18) years old and am fully competent to make my own health care decisions. I am aware of the potential side effects and/or problems associated with prescription medications, including the medications being dispensed by ADV -Care. I agree to truthfully and to the best of my knowledge enter all of the information on my medical registration. I understand and acknowledge that because medical diagnoses, treatments, and opinions differ among the very best, well trained, and respected pharmacists, there is no implied warranty that treatments may benefit me. I also acknowledge that medical and pharmaceutical opinions may differ from time to time depending upon many factors such as medical research, conventions, literature, etc. Any and all questions that I have about my prescription medications and their attendant risks have been answered to my satisfaction. I understand all of the material risks and/or complications that may occur. I also fully understand and agree that by signing this document, I give the licensed Canadian physician who reviews my prescription(s) the right to contact my US prescribing physician(s) with any questions regarding my prescription(s), and/or my medical history. I also agree that if I become aware of any changes in my physical or medical condition in the future and I fail to notify ADV -Care of such changes, then I agree that I am solely responsible for any adverse effects I may suffer from taking or continuing to take these prescribed medications or from participating in this prescription service. I also state that I have had a physical examination by the physician whose care I am under within the last twelve months. By signing each of these pages of this waiver, or clicking "I AGREE" if being submitted electronically, I agree to release from liability and hold harmless ADV -Care from all claims, actions, causes of action, suits, penalties, liens, judgments, liabilities, obligations, losses, and actual, claimed or consequential damages which may arise at any time by reason of or relating to, arising directly or indirectly out of any matter whatsoever related to the dispensing of my prescription medications or other use of this website. I understand that it is my responsibility to have regular physical examinations by the physician whose care I am under including all suggested testing by said physician to ensure I have no medical problems, which could constitute a contraindication to me taking the medications being prescribed and dispensed for me. I agree that should I suffer any adverse effects while taking these prescribed medications that I will immediately contact the physician whose care I am under. Should I come under the care of another physician, I will inform him or her of any and all medications I am taking. I hereby give permission to my physician to release my medical files and medical reports to ADV -Care as needed to obtain sufficient information for the purpose of dispensing my medications. I acknowledge and agree that I initiated this contract with ADV -Care and that it is located in Canada. I acknowledge that the pharmacists working with ADV -Care are licensed to practice pharmacy in Ontario – Canada. I hereby authorize ADV-Care to redirect my prescription for fulfillment of any medications that are temporarily unavailable in Canada and for all controlled medications that cannot be mailed from Canada, to either a fully licensed US or Global mail order pharmacy partner. I understand and acknowledge that ADV -Care recommends regular physical examinations and doctor's office visits with my physician. I further understand that ADV -Care will only verify and dispense medications that my physician whose care I am under has already prescribed for me. I also understand that no controlled medications, narcotics, tranquilizers, or other medication the physician decides is inappropriate will be dispensed. I understand that this service is not in any way intended to diagnose a medical condition. 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. I understand that any opinions, 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. ADV -Care reserves the right to change this disclaimer and the medical registration form at any time, including the terms of consultations. You should read this disclaimer every time you place a new prescription order. Liability in regards to Deception or other Misuse: In rendering the undersigned patient any administrative or other services relating in any way to this agreement, or disclosing information or methods of treatment to the patient (either deemed to be sufficient consideration for this agreement) then, in the event any court determines that the undersigned patient sought medical treatment or prescriptions for the possible or apparent purpose of deception, or any other misuse, directly or indirectly, the undersigned patient knowingly and expressly consents to a judgment of liquidated damages, against the undersigned patient, in the amount of Five Million Dollars (\$5,000,000.00 (U.S.)), which amount is hereby accepted by the undersigned as a reasonable amount for engaging in such acts of deception. If the undersigned patient engages in any of the above-described acts, he/she agrees to pay all reasonable attorney's fees and costs incurred by any legal person seeking to enforce this agreement. This agreement represents the complete and entire agreement between ADV -Care Pharmacy Inc. and myself. I have read and understood the above-referenced "Patient Disclaimer". I declare that I understand this Disclaimer.

Signature: _____

Name (Print): _____ **Date:** _____

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Pre-Authorized Check/Debit Agreement Page 1 of 2



1. Payor's Name and Address - please print

I/We warrant and represent that the following information is accurate.

Mr. Mrs. Ms. Miss	Surname	First Name
Street		
Town	ZIP	Phone No.

Name of Payor's Financial Institution (the "Processing Institution")		
Street		
Town	ZIP	Account No.

I/We have attached a sample check marked "VOID" to this payor authorization (the "Authorization").

I/We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD (Pre-Authorized Debit).

2. Payee's Name and Address

Name of Payee (the "Payee")	ADV-Care Pharmacy Inc.		
Street	195 Riviera Dr. Unit 2		
Town	Markham	Postal Code	L3R 5J6
Phone No.		(905) 948 - 1991	

3. I/We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against my/our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. I/We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization below.

5. I/We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H1 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:

PERSONAL MEDICATION PURCHASE OR BUSINESS USE

6. I/We may cancel the Authorization at any time upon providing written notice to the Payee not to exceed 30 days, to obtain sample of cancelation form or to obtain more information visit www.cdnpay.ca.

7. I/We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by me/us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by me/us.

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Pre-Authorized Check/Debit Agreement Page 2 of 2



8. The Payee will provide to me/us, at the address provided in Section 1:
- (a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to my/our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the **first** PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);
 - (b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of **every** PAD; and
 - (c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of mine/ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a Pad in full or partial payment of a billing received by me/us for a payment obligation that meets the requirements of Section 2 or Rule H1, no notice is required.
9. The Payee may issue a PAD _____ in a dollar amount up to a maximum of \$_____.
(insert frequency of debits)
(If you will be using the e-check debit only once, enter 1 for the frequency and the \$ amount owing. If you are planning on using the e-check debit for future purchases, then leave the space blank.)
10. I/We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued or caused to be issued by the Payee on the Account.
11. Revocation of the Authorization does not terminate any contract for goods or services that exists between me/us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
12. I/We may dispute a PAD only under the following conditions:
- (i) the PAD was not drawn in accordance with the Authorization;
 - (ii) the Authorization was revoked; or
 - (iii) pre-notification, as required under Section 8 was not received.
- I/We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 90 calendar days after the date on which the PAD in dispute was posted to the Account.
- I/We have certain recourse right if any debit does not comply with this agreement. For example, I/We have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain sample of cancelation form or to obtain more information visit www.cdnpay.ca
- I/We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between me/us and the Payee, outside the payments system.
13. I/We agree that the information contained in the Authorization may be disclosed to Royal Bank of Canada as required to complete any PAD transaction.
14. I/We understand and accept the terms of participating in this PAD plan.
15. I/We understand and accept that an additional processing fee of \$10.00 Canadian will be added every time the check/debit service is used.

(Authorized Signature)

(Date)

(Client Name in full)

N.B. Include a void check with your paperwork.