ADVCARE PHARMACY
Grandiosas ofertas todos los dias!

LA FARMACIA EN SU VECINDAD
A LA PUNTA DE SUS DEDOS !

Servicio De Recetas Para Recidentes De Los E.U.A

Para registrarse es muy facil, simplemente siga los 3 siguientes pasos:

1. **Llene en <u>completo</u> la hoja de registracion. Por favor incluye el nombre del doctor que vsted visita actualmente, como contactarlo a su preferencia, metodo de pago, direccion de envio y por favor firme el formulario llamado <u>Patient Disclaimer</u>.**

2. **Su Dr. principal <u>debe</u> llenar la hoja llamada "Patient Customs Statement" dejando la seccion de la mitad en blanco.**

3. **Pregunte al Dr. que usted visita que envie via fax al numero gratuito 1-877-948-0464 el paquete de registracion completamente lleno junto con las recetas medicas y su mas reciente historia medica.**
   O
   usted puede enviar toda esta informacion por correo junto con la recetas originales directamente a nuestra direccion 70 Esna Park Dr. Unit 11, Markham, Ontario, L3R 6E7.

Para asegurarse de no retrasos en su orden, por favor asegurese que **todos** los documentos requeridos sean enviados juntos.

- Registration Form (La hoja de Registracion, incluya su nombre, direccion, *forma de pago etc.)
- Disclaimer Form (Esta hoja debe estar firmada).
- Patient Customs Statement (Esta hoja debe estar firmada).
- Receta escrita por su Dr.
- Historia Medica mas reciente.

Ordenes que no contenga toda la informacion requerida va ha precensiar una demora y/o no envio.

Carga de envio mas un seguro de envio es $9-20 US dependiendo del valor de su compra.

* Su tarjeta de credito podria ser cargada en dollares canadiences.
Si usted esta utilizando nuestro servicio the e-check debito por favor llene la "Autorization for E-check Debit".

Sientace libre de aderir en su orden cualquier suplemento diabetico, productos de salud o belleza, medicinas que no requieran receta y ahorre dinero en su cargo de envio.

Recuerde
Ciertas medicinas no son disponibles in Canada o no pueden ser enviadas sobre la frontera.

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 a fully licensed United States mail order pharmacy.

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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Registration Form

Fillable Form

Personal Information:

Last Name	First Name	Group	Birth date	Gender
			dd/mm/yy	☐ M ☐ F

Contact Information:

Address	City	State/Prov	Zip	Country

Phone	Fax	E-mail

Medical Information:

Medications Currently Taking

Allergies:

Medical Conditions (Please Check)

☐ Pregnancy ☐ Asthma ☐ Cholesterol ☐ Diabetes ☐ Bleeding Disorder
☐ Glaucoma ☐ Heart Condition ☐ Hypertension ☐ Others

If Check Others, Please Specify:

Rx Refill Options: ☐ Refill by E-mail ☐ Refill by Phone

Accept Generic Substitute: ☐ Yes ☐ No

Your Doctor Information:

Doctor Last Name	First Name	Phone	Fax

Doctor Address	City	State/Prov	Zip

Shipping Information (If not the same as contact information above)

Shipping Address	City	State/Prov	Zip	Country

Shipping insurance is mandatory for orders above $100 Canadian Dollars.

Credit Card Information:

Card Holder Name (on card)	Card Number

Method of Payment (check only one):	Expiration (MM/YY)
☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover ☐ 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 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:_____

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 #, the pharmacy will attempt to acquire it.)

FOR PHARMACY USE ONLY
Authorized by Doctor: _____;   who holds a Ontario License # _____   Phone #:_____

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: _____