

NEW PATIENT ORDER FORM

All questions contained in this questionnaire are strictly confidential

Your Full Name: MALE FEMALE Birthdate (MM/DD/YY)

Street Address: City/State/Province:

Phone (Home): Country:
Phone (Other): Zip/Postal Code:

Best time contacted: Height (Feet) (Inches)

Email address: Weight (Pounds):

Secondary Contact (Full name): Phone Number: Relationship:

PERSONAL HEALTH HISTORY

Drug Allergies: No Yes If yes, what are they:

Smoking Currently pregnant or attempting to get pregnant

Is this order for a pet? No Yes Dog Cat

Other (Please specify) Pet Name:

Medication, OTC, Herbal Products You Are Currently Taking (Only list medication you are NOT ordering)

MEDICATION	DOSAGE	FREQUENCY

Would you like to receive a call to remind you of future refills? YES NO

MEDICATION ORDER

For medication(s) that you wish to order, please enter the quantity and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, emailed or called in, from your doctor).

MEDICATION	STRENGTH	QTY	PRICE

Shipping cost \$14 .00 for the US (incl. Puerto Rico), Canada and UK

All other countries \$26.00. For expedited orders phone 1-844-424-3276

*SHIPPING

TOTAL

OPTION 1 (FASTEST) EMAIL OR FAX A COPY OF YOUR PRESCRIPTION(S) AND THEN MAIL ORIGINALS

Scan or use your camera (Smartphone) to take a clear picture of your original prescriptions, and then email them in full quality to:

Prescriptions@CheapoMeds.com
Subject line of your email: Prescription(s) for (type your name)

OR Send by FAX to: 1-844-423-5583 (International: 1-403-206-2231)

Sending the scan will allow your order to continue processing. Please email your original prescription to:

Cheapo
326-1500 14th Street S.W.
Calgary, Alberta, Canada T3C 1C9

OPTION 2: CONTACT YOUR DOCTOR *

Please list the medications you would like us to call your doctor about. (* Option 2 only available to residents of the United States and Canada)

OPTION 2 Prescription Submission

Use this form to submit your prescription(s). Full Name _____
 Send it back to us to complete your order. Phone Number _____

YOUR PHYSICIAN

Primary Physician's Name _____ Clinic Name, Street Address _____
 City _____ State/Province _____ Country _____ Zip/Postal Code _____
 Phone Number _____ Ext. _____ Fax Number _____ Email _____

Payment

<input type="checkbox"/> Personal Check	<input type="checkbox"/> Credit Card
I will mail a certified check to: Cheapo 326-1500 14th Street S.W. Calgary, Alberta, Canada T3C 1C9 Cheapo accepts personal checks, bank drafts, money orders, and certified checks.	<input type="checkbox"/> AMEX Cardholder's Name: _____ Cardholder's Address: _____ City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____ Credit Card Number: _____ Expiry Date (MM/YY): _____ CVV Code: _____

Join Our Referral Program - Earn \$25 Credit.
You can earn \$25 credit by simply referring a friend or family member!
 Name of person who referred you: _____ Their phone number : _____
 Referrer must be an existing patient with a previous order to qualify.

CheapoMeds.com ("Cheapo Consulting") specializes in international mail order pharmaceutical services and facilitates patient access to licensed pharmacies to acquire pharmacy services and medications. The following terms and conditions apply to all transactions between Cheapo and I, the Patient. By accepting services from Cheapo, I agree to be bound by and accept these terms and condition.

- =5A CJ9F H<95: 9C: A5>CF HM-B H<9: F<G8-7HCB K <9F9=@J 9Z5B8.
- I have fully and accurately disclosed my personal and health information and authorize Cheapo Consulting and its affiliated businesses and pharmacy partners to collect and use my information for the fulfillment and delivery of my order. The prescription medications I have requested were lawfully prescribed by a qualified and licensed physician. I have attended, have had a physical examination, and have received a prescription from a duly licensed practitioner within the last year, and do not require an additional physical examination.
 - The licensed pharmacies Cheapo Consulting works with are licensed to dispense, and can only dispense, medications that are approved and authorized for sale within the jurisdiction of their licensed operations.
 - I expressly grant to Cheapo Consulting, and to the licensed pharmacy or pharmacies dispensing medications to I, power of attorney to take all steps, sign all documents, act on my behalf for the purposes of obtaining a prescription recognized and valid within the dispensing pharmacy's home jurisdiction, as well as packaging and shipping the medications to me. This authorization shall include, but not be limited to, the collection of my personal and health information, and the disclosure of such information to any pharmacist, physician, or other health professional being retained on my behalf, as required.
 - Any dispute, complaint demand, claim, or cause of action relating to Cheapo Consulting services will be governed by the laws of the Province of Alberta, and any applicable federal laws of Canada. In such event, I expressly attorn to the jurisdiction of Alberta, and the courts in Alberta will have sole and binding authority to settle any and all disputes.

=GD97 =-75@@M7CB: #A Z577BCK @98: 9588 5: F99H<5H 957< 5B8 9J 9F MCB9C: H<909 H9F A G 5B8 7CB8 #CBQK #<C I H @A H5HCBZK @55DD@MSI HCA 5H75@@M 5B8 < C J 9F B 5BMDK 909H 5B8 < I H F 9 C F 8 9 F G I B @9G5 =G977 =-75@@M88-75H9 CH<9K @9 5H H<9 HA 9 C: C F 8 9 F B: "5BMSI H<CF #SHC8G 5B8 7CB89BH -B7@ 898 -B H<909 H9F A G 5B8 7CB8 #CBGK @7CBH8I 9I BH@=75B79@H<9A Z K <7< =75B 8C 5H 5BMMHA 9< CK 9J 9F Z = =75B79@A MSI H<CF #SHC8B 5B8 7CB89BH7<95D< 7CB8 @HB: A 5M69 I B 5609 HC DF C J -B 9 09 F J 7 90HC A 9 CF =5A H<9 D5F9BH@9 5@: I 5FB-5B#DCK 9F C: 5HICFB@M: CF H<9 D5H-9BH 8-67@C98 <9F9BZ5A C J 9F H<9 5: 9C: A 5<CF #M2588 <5J 9: I @@5I H<CF #MHMC G: B< CF 5B8 DF C J -B 9 H<9 56C J 9F 9F 909BH5HCBGHC H<9 D<5FA 57MCB H<9 D5H-9BH G 69< 5@"

The pharmacy services are performed in the jurisdiction of the licensed pharmacies, in the same way as if I had physically attended the pharmacy's location. Any dispute, complaint, demand, claim, or cause of action relating to pharmacy services will be governed by the laws of the jurisdictions of the pharmacy. In such event, I expressly attorn to the jurisdiction of the pharmacy and the courts that the jurisdiction will have sole and binding authority to settle any and all disputes.

→ _____
 Patient's Signature Date: MM/DD/YY

THANK YOU FOR YOUR ORDER!
 Questions? Call us toll free at 1-844-424-3276
 or visit www.CheapoMeds.com