

Current Order

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained from medaffordglobal.com/ncerx or the customer service center. A valid prescription is required (mailed, emailed or faxed). PRICING IN \$US DOLLARS.

PHARMACY COUNTRY	MEDICATION	STRENGTH	QTY	PRICE
Shipping: Canadian Pharmacy \$9.50; All other pharmacies are FREE				
TOTAL:				

Personal Information

Male
 Female

Full Name (please print clearly) _____

Street Address _____

City _____ State/Province _____ Country _____ Zip/Postal Code _____
 () () ()

Phone (Home) _____ Phone (Other) _____
 / /

Email _____ Birthdate (MM/DD/YY) _____

Group Number: _____

Would you like to receive an email to remind you of future refills? Yes No

Payment Options

Credit Card

Cardholder's Name _____

Cardholder's Address _____

City _____ State/Province _____ Country _____ Zip/Postal Code _____
 () () ()

Credit Card Number _____

Credit Card Expiry (MM/YY) _____ CVV Code _____
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Authorization (Please check all):

- I am over the age of majority, and:
 - 1. I have fully and accurately disclosed my personal information and personal health information and consent to its use for my medication order. I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.
 - 2. I understand that all Products shall be sold & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.
 - 3. I authorize and appoint the Pharmacy, as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.
 - 4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy shall govern all transactions, and I attorn to the courts of the jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the Pharmacy, its affiliates, officers and directors.
 - 5. I understand that, by law, I am unable to return any medication for any reason.
 - 6. I understand that once my order has been placed, I cannot receive a refund for the priced amount of medications on my order.
- OR
- I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations on the Patient's behalf.
 - I have read and agree to the Terms and Conditions for this program listed above.
 - I authorize NBBI Signup to deduct the cost of the brand-name medication(s) selected.

First Time Patients please fill out this section if you are a first time patient, or to update your information.

Your Physician

Primary Physician's Name _____

Clinic Name, Street Address _____

City _____ State/Province _____ Country _____ Zip/Postal Code _____
 () () ()

Phone Number _____ Ext. _____ Fax Number _____

Allergies

Do you have any known drug allergies? Yes No If yes, please enter the drug(s) you are allergic to:

Medication, OTC, Herbal Products You Are Currently Taking (only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY



 Patient's Signature

 Date (MM/DD/YY)

Group Number: NCERXPlus