



5 SIMPLE STEPS TO START SAVING



1. The first step of the process is to fill out the Patient Profile.



2. Complete the Order Form. Make sure to date and sign the second page of the Order Form.



3. Complete the User Agreement. Make sure to date and sign the User Agreement Form.*



4. Combine your Doctor's prescriptions along with the Completed Forms. If paying by cheque/money order, please make payable to **GLENWAY PHARMACY**.



5. Send or Fax Completed Forms along with your Doctor's Prescriptions to:

Mail

P.O. Box 50089
660 Eglinton Ave East
Toronto, Ontario
Canada
M4G 2K0

Toll Free Fax

Fax 1-866-497-9782



* The first 3 steps can be completed by visiting www.affordmeds.com and clicking Order Online. All prescriptions must be written for 90 days plus 3 refills.

Call 1-866-712-4448

660 Eglinton Avenue East P.O. Box 50089 Toronto Ontario Canada M4G 2K0



Patient Profile – Cont'd

Patient Name _____

Patient medical history

Do you have a history or early finding suggestive of the following? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Emotional disorders, stress |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Poor wound healing | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Edema or excessive fluid retention | <input type="checkbox"/> Other illness not yet noted |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Medications use in past year |
| <input type="checkbox"/> Hyperlipidemia (high cholesterol) | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Upper respiratory disorders | <input type="checkbox"/> Renal, bladder or kidney disease |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Lung disorder | <input type="checkbox"/> Drug allergies |
| <input type="checkbox"/> Orthopaedic/Muscle disorder, fracture, joint disorder or carpal tunnel syndrome | |
| <input type="checkbox"/> Thyroid, diabetes or other endocrine disorder, including insulin resistance | |
| <input type="checkbox"/> Heart Disease angina, chest pains, palpitation, heart failure or history of heart attack | |
| <input type="checkbox"/> Any known nutrition deficiency including minerals and electrolytes | |
| <input type="checkbox"/> Rheumatoid arthritis, lupus, or connective tissue diseases | |
| <input type="checkbox"/> Regular exercise | |

What type, frequency and duration of exercise _____

If you checked any of the above questions, please elaborate below. (i.e. duration of illness, any treatment or surgery received, amount smoked and for how long?)



Order Form

Medication Ordered	Dosage	Quantity	Generic	AffordMeds Price \$US

Shipping Charge: \$ 12.00 US

Total: \$ _____ US

CREDIT CARD INFORMATION

Cardholder (name on card) _____

Cardholder Address _____

Credit card Number _____

Credit card expiry _____

Visa

MasterCard

Mailing Address

P.O. Box 50089
660 Eglinton Avenue East
Toronto, Ontario
Canada
M4G 2K0



Order Form – Cont'd

***Visa & Mastercard** are the preferred method of payment. Money orders & personal cheques are acceptable but must clear before processing will begin. This may add up to 7 days to the shipment times. (No third party cheques accepted.)

Please make out all personal cheques and money orders to GLENWAY PHARMACY

***Note** in order to order from the Canadian Licensed Pharmacy you must have been on the medication for a minimum of 30 days.

Informed consent for Patient Counseling:
The pharmacy will provide patient counseling from a licensed pharmacist on all prescriptions.

This includes:

1. Medication identification (name, dose and use)
2. Directions for use and what to do if you miss a dose
3. Drug or food interactions and common side effects
4. Special storage requirements and refill information

Would you like a pharmacist to call to discuss your meds ___yes ___no

Signature: _____ **Date:** _____

PLEASE SIGN USER AGREEMENT ON THE NEXT PAGE

No prescriptions will be filled without a signed copy of this form

Afford 
meds.com
User Agreement

(No prescriptions will be filled without a signed copy of this form)

The undersigned, (hereinafter the Patient") confirms that:

1. The Patient is of the age of majority in the jurisdiction, in which the Patient resides and is fully competent to make their own health care decisions.
2. The Patient confirms that the pharmaceutical(s) ordered by the Patient ("the Ordered Product") were prescribed by a duly qualified medical practitioner in the place of residence of the Patient. The Patient has not violated any laws in obtaining the prescription and that the Ordered Product will not be used by any other person and in no manner except as prescribed by the original prescribing physician ("The Patient's Physician").
3. By reviewing the Patient's medical information, the Canadian Physician is not providing any service or advice to the Patient. The Patient confirms that they did not request a medical opinion of the Canadian Licensed co-signing Physician regarding the Ordered Product. The Patient agrees to direct all questions to The Patient's Physician. The Patient will consult The Patient's Physician before taking any new drug, natural product, or changing their daily health regiment.
4. The Canadian Licensed Pharmacy requires the patient to submit a new medical questionnaire every time there is a change to their medical status. The Patient understands that it is their responsibility to have The Patient's Physician conduct regular physical examinations (minimum every 12 months), including any and all suggested testing by The Patient's Physician to ensure that they have no medical problems which would constitute a contradiction to them taking medications prescribed for them. The Patient agrees that should they suffer any adverse affects while taking any prescription medication that they will immediately contact The Patient's Physician and that in the event they come under the care of another physician, the Patient will inform this physician of any and all medications that have been prescribed.
5. The Patient agrees to release and discharge The participating Canadian Licensed Pharmacy and all of its Employees & Contractors, including the Doctors and Pharmacists, from all liability, claims, or causes of action with respect to any side effects, the appropriateness, suitability, strength or dosages of the pharmaceutical(s) prescribed for the undersigned.
6. The Patient understands and acknowledges that the Ordered Product(s) will not be packaged in child protective packaging. The Patient assumes all responsibility for safe and secure storage, restricting non-patient access to the medications.
7. The Patient releases and discharges the Canadian Licensed Pharmacy, its contractors and its Employees from any and all causes of action with respect to the late delivery, non-delivery or missed delivery of the Ordered Product(s) sent to the Patient. The Patient must take responsibility to secure their own medication stock from a local pharmacy in the interim if such an event was to evolve, ensuring that at no point they are without medication.
8. The Patient grants Limited Power of Attorney to Canadian Licensed Pharmacy, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), or Ontario (Canada), which are necessary to permit the delivery of the Ordered Product to the Patient, in the same manner as the Patient could, if the Patient had personally attended the pharmacy in Winnipeg, Manitoba, Canada.
9. The Patient agrees that any dispute that arises between Him or Her and the Canadian Licensed Pharmacy shall be heard by the courts of Manitoba, Canada. The courts of Manitoba, Canada shall have the sole and exclusive jurisdiction, and that the laws in force in Manitoba, Canada, shall apply to any and all disputes that may arise.
10. The Patient must honestly report all requested information and immediately update any changes to his or her record.
11. The Patient understands that the Ordered Product may not be exchanged or returned for a refund once purchased and shipped.

BY SIGNING THIS DOCUMENT THE PATIENT CONFIRMS THAT HE OR SHE HAS READ AND UNDERSTOOD EACH OF THE ABOVE TERMS AND HAS AGREED TO EACH ONE.

Name: _____ **Date:** _____ **Signature:** _____