US Resident Service

Patient Customs Statement

The undersigned hereby acknowledges, confirms and certifies that the enclosed medications/healthcare products are imported to the USA solely for personal use for a period not exceeding 3 months as allowed under the FDA personal importation rules and guidance.

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:____

US Resident Service
Registration Form

Registration Form

Personal Information:

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

Contact Information:

Address	City	State/Prov	Zip	Country

Home Phone	Fax	E-mail

Medical Information:

Medications Currently Taking

Allergies: No, Known Allergies Yes, Please Specify:

Medical Conditions (Please Check)

Pregnancy Asthma Cholesterol Diabetes Bleeding Disorder
Glaucoma Heart Condition Hypertension Hysterectomy

Other Medical Conditions, 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 Dollars.

Credit Card Information:

Card Holder Name (on card)	Card Number

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

By signing below, I authorize Healthy Way Rx to check the accuracy of the personal information I have provided. I understand that in order to verify my personal information, Healthy Way Rx may disclose my personal information to the third parties and such third parties may provide verification of such personal information to Healthy Way Rx from information they have previously collected about me. I also, authorize Healthy Way Rx 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 Healthy Way Rx, including all of its employees, agents, representatives and contractors including physicians, pharmacists, pharmacy technicians, nurses, and receptionists ("Healthy Way Rx") 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 Healthy Way Rx and any adverse effects I may suffer from these medications dispensed by Healthy Way Rx. 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 Healthy Way Rx. 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 Healthy Way Rx 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 Healthy Way Rx 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 o f 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 Healthy Way Rx as needed to obtain sufficient information for the purpose of dispensing my medications. I acknowledge and agree that I initiated this contract with Healthy Way Rx and that it is located in Canada. I acknowledge that the pharmacists working with Healthy Way Rx are licensed to practice pharmacy in Ontario – Canada. I hereby authorize Healthy Way Rx 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 Healthy Way Rx recommends regular physical examinations and doctor's office visits with my physician. I further understand that Healthy Way Rx 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 parti- ties (including merchants and licensors) are those of the respective authors or distributors of such content. Healthy Way Rx 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 Healthy Way Rx and myself. I have read and understood the above-referenced "Patient Disclaimer". I declare that I understand this Disclaimer. I also consent to recieve electronc communications from Healthy Way Rx by phone, e-mail, SMS, fax or any communication means.

Signature: ___________________________

Name (Print): ___________________________ **Date:** ___________________