

Getting Started



Thank you for your interest in our prescription service!!

If you need any information regarding the price of your prescription(s) or have any questions please contact us toll-free at **1-800-784-2309** or visit our website at **www.polarmeds.com**.

HOW TO ORDER YOUR MEDICATIONS

Step 1: Please complete and sign the 3 forms attached (ie. Patient Medical Questionnaire, Medication Order Form, and Release Form). You will only have to fill out these forms the first time you order from us. Any information you provide will be kept strictly confidential.

Step 2: Simply mail the 3 forms back to us along with your original prescriptions (with additional refills indicated), OR to save mailing time, fax it toll-free to 1-888-875-0946.

Mail to:
PolarMeds Inc.
200-1383 Pembina Hwy
Winnipeg, Manitoba
R3T 2B9 Canada



Proud Member
of the
**Better Business
Bureau**

CHARGES

1. Drug cost as quoted on our website or by our staff. (Prices subject to change)
2. Shipping fee is a flat rate of \$15.00 per package. (Not per drug, but per shipment)

PAYMENT

We accept VISA, MasterCard, checks and international money orders made out to PolarMeds Inc. There is an additional 5-day waiting period for banking authorization on personal checks.

SHIPPING AND PROCESSING

Once we receive your completed order, we require 2 weeks for processing and shipping. All orders are shipped via Canada Post and the U.S. Postal Service.

REFILL POLICY

When obtaining your new prescription please make sure that it has refills on it. Having refills on a prescription makes re-ordering your medications easier and quicker. No questionnaire needs to be filled out for refills unless your medical condition has changed. After your refills are completed, a new prescription from your physician is required.

PLEASE BE ADVISED

The U.S. FDA limits the quantity of medication that you can order to a maximum of a 3-month supply. If your prescription allows refills, you can simply call us to order your refill.

We are not allowed to ship controlled substances such as amphetamines, benzodiazepines (e.g. Valium), or narcotics such as codeine and morphine.

Most American insurance companies will accept receipts issued from a Canadian pharmacy, however, patients with drug insurance plans should contact their insurance company first before ordering.

Our service is open to anyone. Please feel free to give our toll-free number or website address to friends and family, or make copies of these forms as you require. Thank you.

Please keep this page for your records. You do not need to fax or mail this page.

Return by mail to: 200-1383 Pembina Hwy. * Winnipeg, Manitoba * Canada R3T 2B9

or fax to: 1.888.875.0946
Call us toll free: 1.800.784.2309

**This form as well as the release form needs to be submitted only on the first order*

Patient Information

Full Name _____ Date _____

Mailing Address _____

City _____ State _____ Zip _____

() _____ () _____

Home Phone _____ Work / Cell Phone _____

E-mail Address _____ How did you hear about us? (newspaper, friend, web, etc.) _____

Age _____

Height _____

Weight _____

Sex _____ / _____ / _____

Date of Birth (mm/dd/yy) _____

Physician Information

Full Name _____

Address _____

() _____ () _____

Phone _____ Fax _____

It is mandatory to have had a physical examination in the last 12 months.

Have you had one? Y N

If you have previously filled out a form, please indicate if there are any changes:

Y N First Patient Form

Patient History

Please provide the following information (if you require more space, attach a separate piece of paper):

1) Operations (eg. Hysterectomy, Gall Bladder, Heart Operations, etc.):

3) Present Illness (ongoing, eg. Diabetes, Heart Disease, Osteoporosis, etc.):

4) Do you have any known drug allergies? Y N

If yes, please enter the drug(s) to which you are allergic: _____

Current Medications (please list all medications that you are currently taking, including dosage and frequency)

| Medication Name | Strength / Dosage | Directions of use |
|-----------------|-------------------|-------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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or fax to: **1.888.875.0946**
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**No prescriptions will be filled without a signed and dated copy of this form*

The Undersigned (hereinafter the "Client") confirms that:

1. The Client is of the age of majority in the jurisdiction in which the Client ordinarily resides. ("Place of Residence")
2. The Client is not restricted from making his or her own medical decisions under the laws of the Place of Residence of the Client.
3. The Client confirms to PolarMeds.com and PolarMeds Inc. (hereinafter "The Providers") that the pharmaceutical(s) ordered by the Client (the "Ordered Product") were prescribed by a duly qualified medical practitioner in the Place of Residence of the Client.
4. The Client has not violated any laws in the Place of Residence of the Client in obtaining the prescription for the Ordered Product.
5. The Client confirms that the Ordered Product will not be used in any way whatsoever, except as prescribed by the duly qualified medical practitioner who issued the Prescription to the client (the "Client's Doctor").
6. The Client confirms that no person other than the Client will use the Ordered Product.
7. The Client grants Limited Power of Attorney to The Providers, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the Ordered Product to the Client, in the same manner as the Client could, if the Client had personally attended at The Providers place of business in Winnipeg, Manitoba, Canada.
8. The Client attorns to the jurisdiction of Manitoba and agrees that any dispute that arises between the Client and the Providers shall be governed by the laws of the Province of Manitoba and the Federal Government of Canada, as applicable.
9. The Client further agrees that if any dispute, shall arise between the Parties pursuant to this Agreement as to the rights or liabilities of the Parties to this Agreement, then every such dispute shall be referred to a single arbitrator if the parties can agree on one. Otherwise, upon motion of either party to any Judge of the Court of Queen's Bench for Manitoba such judge shall be entitled to name a single arbitrator, whose appointment shall be final and binding upon the parties. In all respects, subjects to the terms of this agreement, The Arbitration Act of Manitoba and amendments there to shall govern such proceedings and the arbitrator shall be entitled to fix and apportion liability for the costs of the arbitration. The award or determination which shall be made by the said arbitrator shall be absolutely final and binding upon the parties.
10. The Client acknowledges that the Ordered Product may not be returned for a refund or an exchange.

BY SIGNING THIS DOCUMENT THE CLIENT CONFIRMS THAT HE/SHE HAS READ AND UNDERSTOOD THESE TERMS AND THAT THEY ARE TRUE AND CORRECT AND THE CLIENT AGREES THAT THE TERMS HEREIN ARE BINDING ON THE CLIENT AND THE HEIRS ASSIGNS, SUCCESSORS AND PERSONAL REPRESENTATIVES OF THE CLIENT.

Patient Name (Print)

Patient Signature

Date

Return by mail to: **200-1383 Pembina Hwy. * Winnipeg, Manitoba * Canada R3T 2B9**

 or fax to: **1.888.875.0946**
 Call us toll free: **1.800.784.2309**
**Original prescriptions must accompany this form - faxed or mailed in*

_____ () _____ ()
 Full Name Home Phone Work Phone

Important: In the spaces provided below please write the medications that you would like us to fill for you at this time. Any medications not written here, but which you have sent a prescription for, will not be filled at this time. These prescriptions will be filed on our computer and may be filled at a later date.

| Medication Name | Strength | Quantity | Generic OK? | Price |
|--|----------|----------|---|----------------|
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| | | | <input type="radio"/> Y <input type="radio"/> N | |
| Add Shipping & Handling (Trackable Insured Shipping via Express Post) | | | | \$15.00 |
| Total Enclosed (U.S. Funds) | | | | |

//visit our website at www.polarmeds.com

Manitoba law requires that we contact you to offer patient counselling. A representative from our pharmacy will contact you. Please indicate the best time and the appropriate phone number to call to get a hold of you.

 Check circle if you do NOT want childproof caps:
Payment Method
 Visa Mastercard International Money Order Check (Certified/Personal)

 Credit Card No.

 Expiration Date (mm/yy)

 Card Holder Name

 Card Holder's Signature