

Getting Started



Thank you for your interest in our prescription service. American patients can save from 30-80% on the cost of their medications by getting their prescriptions filled through our Canadian Pharmacy. Our prescription service allows American patients to access the same medications that are available in the U.S., but at much lower Canadian Prices.

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 2 forms attached (ie. Patient Order Form and Prescription Request 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 2 forms back to us along with your original prescriptions (if applicable), 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

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. 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 up to 14 working days 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.

Patient Order Form

Personal Information

Male
 Female

Full Name _____

Street Address _____

City _____ State _____ Country _____ Zip code _____
 () ()

Phone (home) _____ Phone (work /cell) _____

Birthdate (mm/dd/yy) _____ Email Address _____

Best time to be contacted by a Pharmacist _____

Would you like to receive a call to remind you of future refills? Yes No

First Time Patients

(please fill out this section if you are a first time patient)

Secondary Contact

Full Name _____

Relationship to You _____ Phone Number _____

Physician Information

Full Name _____

Address _____

Phone Number _____ Fax Number _____

Known Allergies

 Do you have any drug allergies? Yes No If yes please specify: _____

Current Medications (please list only the medications that you are NOT ordering)

MEDICATION	STRENGTH	FREQUENCY

Referral Program (complete to earn credits for yourself and the person who referred you)

Full Name of person who referred you _____ Phone Number _____

Payment Options

 Visa Mastercard International Money Order Check (Certified/Personal) **Please make cheque payable to : PolarMeds**

Credit Card No. _____

Card Holder Name _____

Expiration Date (mm/yy) _____

Card Holder's Signature _____

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 agent. An original prescription from your doctor's office is required (mailed, faxed or emailed) **PRICING IN \$US DOLLARS**

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
			SHIPPING	\$15.00
TOTAL ((U.S. Funds)				

Patient Agreement

I acknowledge and agree with Polarmeds.com and PolarMeds Inc. (hereinafter "The Providers") as follows:

- I am 18 years old or older in the jurisdiction that I reside.
- I have fully and accurately disclosed my personal and medical information and consent to its use by The Providers and its employees and agents.
- I authorize The Providers 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 Canadian Prescription for any prescription which I have sent The Providers; and (b) packaging my prescriptions and having them delivered to me.
- Title to my medications passes from The Providers to me when they have left The Providers pharmacy location. All agreements reached or contracts formed with The Providers shall be deemed to be made in the Province of Manitoba, Canada and the laws of the Province of Manitoba shall have sole and exclusive jurisdiction over any dispute arising between myself and The Providers, it's affiliates, parent company, related companies, subsidiaries, officers, directors and employees.
- This agreement shall apply to every sale by The Providers to me and may not be altered unless in writing and signed by both The Providers and me.
- I acknowledge that due to the nature of the products ordered, all sales are final and I cannot return products for refund or exchange.

By signing this document, I confirm I have read and understood these terms and that my information is true and correct. Furthermore, I agree that the terms herein are binding on me and my heirs, assigns, successors and personal representatives.

X

Patient Signature

Date (mm/dd/yy) _____

Affiliate Box

Enter Affiliate Code, if applicable


 Proud Member
 of the
**Better Business
 Bureau**

Prescription Request Form

Please use this form to submit your prescription(s), and send it back to us to complete your order.

Full Name _____
() _____
Phone Number _____ Order Number (if available) _____

Option #1: Contact My Doctor

Physician Name _____
Street Address _____
City _____ State _____ Country _____ Zip code _____
() _____ () _____
Phone Number _____ Ext. _____ Fax Number _____

Option #2: Transfer From Another Pharmacy

Pharmacy Name _____
Street Address _____
City _____ State _____ Country _____ Zip code _____
() _____ () _____
Phone Number _____ Ext. _____ Fax Number _____

Please list the medications you would like us to call your doctor for, or to transfer from another pharmacy.

Drug Name	Strength	Directions	Rx Number

Option #3: Mail Your Prescription

Please mail your prescription and this form to:

PolarMeds Inc.
200-1383 Pembina Hwy
Winnipeg, MB
R3T 2B9 Canada