Polarbear meds.com

New Patient Order Form

Phone: 1.888.779.2193
Fax: 1-888-348-6515
Text: 1-431-303-4980
Email: support@polarbearmeds.com
Website: www.polarbearmeds.com

Mailing Address

PO BOX 61067
Grant Park
Winnipeg, MB
R3M 3X8

Personal Information

Full Name (please print clearly) ☐ Male ☐ Female

Street Address

City State Country Zip Code

Phone (Home) Phone (Other)

Email Birth date (MM/DD/YY)

Best time to be contacted

Height Weight: (Pounds)

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

Medications To Order

Please enter the quantity and listed price for the medication(s) you wish to order, as obtained through our website or customer service center. An original prescription from your doctor s office is required (faxed, mailed, emailed or called in from your Doctor). **PRICING IS IN $US DOLLARS.**

Genric OK?	MEDICATION	STRENGTH	QTY	Price
			SUB TOTAL :	
UNITED STATES (excludes: Hawaii & Puerto Rico): $9.99 on all orders $100 or more. Otherwise $14.99 ALL OTHER COUNTRIES: $29.99			**SHIPPING :**	
			Total :	

PAYMENT OPTIONS

Pay by Credit Card

☐ Please call me to obtain my credit card information

Credit Card ☐ Visa ☐ Master Card

Card Holder's Name: ____________________

Card Holder's Address: ____________________ City: ____________________

State: __________ Zip Code: __________

Credit Card Number: ____________________

Expiry Date: __________ CVV: __________ CVV Code

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 Country Zip Code

Phone Number Ext.

Fax Number Email

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

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

Referral Rewards Program

Save $20 on your order. Simply tell us who referred you.

Full name of person who referred you

Phone Number

Prescription Submission

(Please select one of the three options below.)

☐ **Option 1 - (QUICKEST Method)**

Email or Fax a copy of your prescription(s) and then mail originals to the address provided at the top of the first page.

☐ **Option 2 - Call My Doctor**

Please list the Me dications You Wo uld Like Us To Call You r Doctor About

Drug Name	Strength	Directions	RX Number

Contacting your doctor is only available to residents of the United States

Other Contacts - Your Physician

Primary Physician's Name

Clinic Name, Street Address

City State Country Zip Code

Phone Number Ext.

Fax Number Email

☐ **Option 3 - Transfer from another pharmacy**

Pharmacy Name

Street Address

City State Country Zip Code

Medication, OTC, Herbal Products You Are Currently Taking

(Only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

I give the below person(s) consent to order on my behalf

Full name of Contact: ________________

Relationship to You: ________________

Phone Number: ______________________

Email Address: ______________________

Full name of Contact: ________________

Relationship to You: ________________

Phone Number: ______________________

Email Address: ______________________

Patient Authorization (Please check one):

Polarbear Meds operates a marketing and call centre business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription service pharmacy. The following terms and conditions govern the sales as between Polarbear Meds authorized dispensary (the"Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that,

☐ 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 by the Pharmacy, 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.
(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.
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

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.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES.

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 to the Pharmacy on the Patient's behalf.

______________________________________ / / __________

Patient's Signature Date(MM/DD/YY