FOR THE NEW CUSTOMER:

Thank you for your interest in our prescription service. In order to fill your prescription, we will require certain information from you which includes:

1) Signed Patient Agreement (printout included in this information package)
2) Patient Medical Information and Order Forms (printouts included)
3) Your prescription(s)

Note: If you do not have a copy of your prescription, we will need your physician's name, phone and fax number so that we may contact him to receive a copy of the prescription.

You may place your order using the 2-step process listed below.
A representative can check the cost of your prescription, or you may search our online database for pricing.

Step 1. Complete and Sign the:

a. **Patient Medical Information Form**
b. **Patient Agreement**
c. **Order Form**

Step 2. Send us your order.

There are three ways to send in your order:

a. **Mail the signed forms and the original prescription to us.**
b. **Mail the signed forms and we will call your doctor for a faxed copy of your prescription.**
c. **Fax the signed forms to our toll free fax number 1-877-807-4831 and have your doctor fax a us copy of your prescription.**

Currently we are unable to transfer prescriptions from other pharmacies. It will take approximately two weeks for your medicine to arrive after we receive your order.

Toll Free Fax:	**1- 877- 807- 4831**
Mail to:	**Norphar.com** **1412 Berkshire Dr.** **Austin, TX 78723**

Shipping Charges are $15.00 USD per package (NOT PER DRUG).

This completed Patient Agreement must be delivered to North American Pharmacy Network (operating as Norphar, norphar.com or Norphar Network) by any patient seeking to have Norphar and one of it's associated pharmacies fill a prescription which has been issued by a non-Canadian physician.

Patient Agreement

By signing this Agreement below, I agree that:

1. Under Canadian law, Norphar and its affiliated pharmacies cannot fill my prescription request until a licensed Canadian physician (the "Canadian Physician") reviews my medical information and makes an independent judgment regarding the medications prescribed by my personal physician ("My Local Physician").
2. The Canadian Physician is not rendering or providing any service or advice to me by reviewing my medical information. It is my responsibility to have My Local Physician conduct regular physical examinations of me, including testing suggested by My Local Physician, to ensure that I have no medical problems which would constitute a contraindication to my use of medications prescribed by My Local Physician. If I suffer any adverse affects while taking any prescription medication, I will immediately contact My Local Physician. If I come under the care of another physician, I will inform him or her of all medications that have been prescribed for me. I acknowledge that Norphar and it's affiliated pharmacies recommends regular physician examinations with My Local Physician whose care I am under and who initially prescribed my medications.
3. I hereby give permission to My Local Physician to release all medical information and data requested by Norphar for the purpose of reviewing my medical information. I understand that this will include reviewing my Patient Medical Information Form and any information submitted by My Local Physician.
4. I understand that information provided to Norphar and it's affiliated pharmacies may be seen by its employees, agents and contractors and that this information will constitute a medical record.
5. I understand that Norphar and it's affiliated pharmacies will only verify and prescribe medications that My Local Physician has already prescribed to me. The Canadian Physician cannot prescribe any additional medications. I understand that the Canadian Physician will not approve any controlled medications, narcotics, tranquilizers, or other medications that he or she determines not to be appropriate.
6. I waive any requirement that the Canadian Physician examine me physically.
7. The review of my medical information by the Canadian Physician is in no way intended as a means to diagnose any medical condition and is no substitute for obtaining my own professional medical advice from My Local Physician. I agree to a direct all medical questions to My Local Physician. I will consult My Local Physician before taking any new medication or changing my daily health regimen. Any opinions, advice, statements, services, offers or other information expressed or made available by third parties (including merchants and licensors) are those of the respective authors or distributors.

SIGNATURE _____ **DATE** _____

Patient Agreement Contd. on Back

Patient Agreement Contd.

8. I confirm that I am eighteen years of age or older and that I am competent to make my own health care decisions. I am aware of the potential side effects and problems associated with prescription medications and understand that I would be violating law if I falsify any information on my Patient Medical Information Form or other medical records for the purposes of obtaining prescription medication.
9. I agree to answer all questions on Patient Medical Information Form truthfully and to the best of my knowledge. I agree that if I fail in any way to furnish my complete and accurate medical history, and do not correct such failure, I am solely responsible for any adverse effects that I may suffer from taking or continuing to take medications supplied by Norphar. I agree that I will notify Norphar of any changes in my physical or medical condition, and if I fail to notify Norphar of such changes, I am solely responsible for any adverse effects that I may suffer from taking or continuing to take medications supplied by Norphar.
10. I certify that I have had a physical examination by My Local Physician within the last 12 months.
11. Norphar provides administrative and marketing services to Canadian pharmacies engaged in filling prescriptions for individuals residing in the United States. I acknowledge and agree that Norphar does not provide any clinical or dispensing services and that it has no liability with respect to the appropriateness, suitability, strength or dosages of the medications prescribed or dispensed to me, including without limitation, any dispensing errors or side effects or ill effects of any kind.
12. Due to the nature of prescription medications and requirements of Canadian and U.S. law, medications are not returnable. All sales are final.
13. I acknowledge and agree that I am not relying on Norphar with respect to the dispensing of prescribed medications other than to forward the prescription to the dispensing pharmacy. Any disputes regarding the dispensing, shipping or other matters relating to the prescription are exclusively between me and the Canadian pharmacy whose name and address appears on the prescription container.

SIGNATURE _____ **DATE** _____

Referral Program:
We are now offering additional discounts for referrals. If you are responding as a referral from someone, please fill out the following so they may receive their discount:

The Name of the person that referred you: _____

Their address and/or phone number: _____
_____
_____
_____

Return by mail to: Norphar, 1412 Berkshire Dr., Austin, TX 78723
or fax to: 1-877-807-4831

Patient Medical Information Form (Please Print)

Have you filled out this form before? Yes ☐ No ☐

Your Personal Information

Name: _____
Street Address: _____
Address (cont.): _____
City: _____ State/Province _____ Zip Code:_____
Work Phone: _____ Home Phone:_____
E-mail: _____
Date of Birth: _____ Sex: _____ Height_____Weight_____

You MUST answer ALL of the following QUESTIONS for your order to be FILLED.
Have you had a physical examination by a qualified medical doctor in the last 12 months? Yes ☐ No ☐
(Note: This is mandatory in order to have a Canadian physician countersign your prescription)

Personal Medical Information

Do you have a history of or any early findings suggestive of the following?

Condition	Yes	No	Please describe
Blood Disorders (sickle cell, G6PD, platelet disorders, blood clots in legs or lungs)			
Cancer			
Immune Disorders (HIV or ARC)			
Gastrointestinal tract disorders (Peptic Ulcers, Esophageal Reflux, Colitis, Crohns, Celiac Disease, Diverticulits, Pancreatitis)			
Neurological disorders (epilepsy, stroke, TIA, migraines, parkinsons, multiple sclerosis)			
Endocrine disease (Diabetes, thyroid disease, adrenal disease either cushings or addisons)			
Lung Disorders (Asthma, COPD, emphysema)			
Lipid or Cholesterol disorder			
Heart Disease (Heart failure, angina, MI, pacemaker, atrial fibrillation, ventricular arrhythmia)			
Renal or Kidney Disease (Renal failure, renal artery stenosis, glomerulonephritis, nephrotic syndrome, kidney stones)			

Patient Medical Information Form Contd. on Back of Page

Patient Medical Information Form Contd. (Please Print)

Liver Disease (Infectious hepatitis, hemochromatosis, cirrhosis)			
Orthopedic or muscle disease			
Emotional Disorders (Major Depression, Schizophrenia, ADHD, anorexia bulimia, hospitalization for above)			
Glaucoma			
Allergies To Drugs & Other			
Past Hospitalization or Surgery (Including transplant surgery)			
Lifestyle Risk (smoking, alcohol, overweight, OTC diet pills, chronic pain medications)			

Please tell us about any illness or medical condition you have not listed above:

_____
_____
_____
_____

Please list all allergies to drugs and other: _____
_____
_____

Please list all current medications. (Include over-the-counter medications and Herbal Medications)

NAME	STRENGTH	DIRECTIONS

I confirm that all information provided is true and correct to the best of my knowledge. I give Norphar permission to contact my physician to request additional medical information. I consent to release of requested additional medical information by my physician..

Patient Signature: _____ Date: _____

Return by mail to: Norphar, 1412 Berkshire Dr., Austin, TX 78723
or fax to: 1-877-807-4831

Order Form (Please Print)

Your Family Physician Information:
(Please provide information for your Primary Physician)
Doctor's Name: _____
Street Address: _____
Address (cont.): _____
City: _____ **State/Province** _____
Zip Code: _____
Work Phone: _____ **Home Phone:** _____

Your Order

NOTE: ORIGINAL PRESCRIPTION MUST BE SUBMITTED WITH THE ORDER
(Faxed by Doctor's Office or Mailed)

Medication Ordered	Dosage	Quantity	Price Quoted

Payment:

Visa ☐ MasterCard ☐ American Express ☐ Money Order ☐

Name on Card: _____

Credit Card # : _____ Exp:_____

Have you had this medication before Yes ☐ No ☐

Signature: _____Date: _____

Note: When you receive your order, the receipt will be in Canadian dollars. There are **approximately** 1.54 Canadian dollars for each American dollar, so the prices will **appear** higher. Do not be alarmed, when your credit card company converts the currency, your bill will reflect the prices you were quoted. Also, you may notice a dispensing fee, this fee has already been included in the price of your drugs and is only shown separately on the receipt as required by Canadian law, but **it is not an additional fee**.

Return by mail to: Norphar Network, 1412 Berkshire Dr., Austin, TX 78723
or fax to: 1-877-807-4831