

- ✓ Please fax these forms along with your original doctor's prescription form toll free to 1-888-779-3784 or mail these forms and prescription to: Mailscripts, Inc. 605 W. Main Street, Saint Charles, IL 60174
- ✓ Visit www.msi.0catch.com for order forms and contact information
- ✓ Call us toll free at **1-888-479-3789** for help 24 hours per day

HOW DID YOU HEAR ABOUT MAILSCRIPTS? (Please check one & give name)

My Personal Representatives: Kristin M. Jones 630-768-0647 and Eric R. Jones 630-768-0761
Doctor's Office _____ Business _____

GENERAL CLIENT INFORMATION

Mr. Ms. Mrs. Miss Dr. Other _____

Discount Code - AG5D-17

First / Middle / Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone (incl. area code): _____ Work Phone: _____

Fax (incl. area code): _____ E-Mail: _____

Your Height & Weight: _____ Date of Birth (MM/DD/YYYY): _____

Gender: **Male** **Female**

YOUR PHYSICIAN INFORMATION

First / Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

YOUR PERSONAL MEDICAL HISTORY

Have you had a complete physical examination in the past 12 months? **YES** **NO**

Have you filled out a questionnaire with us before? **YES** **NO**

Please list any drug allergies you have and describe the reactions:

(continue on separate sheet if required)

Please check all of the below which apply to you:

Condition	YES	NO	Condition	YES	NO
Blood Disorders			Migraine Headaches		
Cancer			Emotional Disorders		
Immune Disorders			Surgery		
Poor Wound Healing			Glaucoma		
Neurological Disorders			Chemical Dependency		
Diabetes, Thyroid, or other Endocrine Disorders			Upper Respiratory Disorders		
Cholesterol or Lipid disorders			Smoker		
Known nutrition deficiency including minerals or electrolytes			Lung Disorder including asthma or emphysema		
Heart Disease including angina, heart failure, history of heart attack or atherosclerosis			Rheumatoid arthritis, Lupus, or connective tissue diseases		
Renal or Kidney Disease			High Blood Pressure		
Liver Disease			Fluid Retention or Edema		
Orthopedic or Muscle Disorder including Carpal Tunnel Syndrome			Bone or joint disorder including bone fracture		
Other conditions					

If you answered yes to any of these questions please give us more information including any family history and the duration of illness, date of illness, treatment received, amount smoked etc.

(continue on separate sheet if required)

CURRENT MEDICATIONS (continue on separate sheet if required)

Please list all medications you are currently taking at this time including over the counter medications and herbals / vitamins:

Name of Drug	Date First Prescribed	Strength	Condition treated with this medication	Usage Instructions
Example	12/20/2001	20 mg	Cholesterol	1 tablet per day

ORDERED MEDICATIONS (continue on separate sheet if required)

Please list all medications you are requesting in this order:

Name of Drug	Date First Prescribed	Strength	Quantity (we ship in manufacturer quantities only and suggest a 90 day supply)	US\$ Cost (see our website, or we will call you to confirm pricing)
ORDER TOTAL:				\$
PLUS SHIPPING:				\$15.00
GRAND TOTAL:				\$

Generic Drugs

High quality Canadian Generic Drugs are often available at a lower cost. Would you like your order filled with Generic Drugs when possible? **YES NO**

Pharmacy Counseling

Consultations with our licensed professional pharmacists can provide you with important information regarding your prescription medications and are completely confidential. Would you like a pharmacist to contact you for a consultation? **YES NO**

PAYMENT METHOD

VISA, MasterCard, American Express, International Money Orders or Bank Drafts are accepted for your convenience. International Money Orders or Bank Drafts will delay processing your order and should be made out to Canada Direct Pharmacy Ltd. and faxed with this form and then mailed to our administration center at: **Mailscripts, Inc. 605 W. Main Street, Saint Charles, IL 60174.**

By signing below, I authorize my credit card to be charged for the medications ordered plus US\$15 for shipping costs:

Card Holder Name: _____ Signature _____

Card Holder Address (as it appears on your billing statement): _____

Card Holder City / State / Zip: _____

Card Type: MasterCard Visa American Express

Credit Card Number: _____ Expiry (MM/YYYY): _____

Date Signed (MM/DD/YYYY): _____

Power of Attorney and Release

THESE CLAUSES AFFECT YOUR LEGAL RIGHTS. PLEASE READ THEM CAREFULLY.

1. I acknowledge that Mailscripts Inc. utilizes Canada Direct Pharmacy Ltd. for fulfillment of all orders.
2. I hereby consent to Canada Direct Pharmacy Ltd. collecting my personal and medical information, maintaining the information to quickly process future orders which may include retaining on file my name, address, phone number, payment and other information and required to verify future orders.
3. I acknowledge and understand that all prescription orders sent to Canada Direct Pharmacy Ltd. are verified by a qualified doctor and then filled and shipped by licensed pharmacists in Canada who are agents of Canada Direct Pharmacy Ltd. All prescriptions will be filled only under the applicable laws and requirements of Canada and the Province of Alberta. In the event that Canada Direct Pharmacy Ltd. fills the prescription(s) in a Province other than Alberta, the undersigned hereby acknowledges and agrees that any and all agreements reached or contracts formed throughout the course of the relationship between the undersigned and Canada Direct Pharmacy Ltd. shall be governed by the laws of the Province in which the prescriptions are filled, and accordingly shall be governed by the laws of such Province and the laws of Canada as applicable.
4. I represent and confirm to Canada Direct Pharmacy Ltd.:
 - a. I am over the age of majority in the place that I reside;
 - b. The pharmaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state, or other applicable jurisdiction in which I reside, and that Canada Direct Pharmacy Ltd. may contact my doctor to review my medical file for the purpose of filling said prescription, and that the prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician;
 - c. The pharmaceutical(s) will be used only as directed and only by the person for whom the pharmaceutical was prescribed and will not be filled at any other pharmacy at any other time and that the prescription has not been altered and will not be sold or transferred to any other person;
 - d. It is my responsibility to have regular physical examinations and adequate care by a licensed United States physician to ensure I have no medical problems that would constitute a contradiction to taking medications prescribed for me.
5. I acknowledge that Canada Direct Pharmacy Ltd. has relied on the information and documentation provided by me and that I have fully disclosed all pertinent requested information. I will also notify my prescribing doctor and Canada Direct Pharmacy Ltd. of any changes to my medical condition by sending a facsimile copy of the changes to 1-888-7Rx-Drugs in confidence.
6. I authorize and appoint Canada Direct Pharmacy Ltd., as my agent and my attorney for the limited purpose of taking all steps and signing all documents to obtain a prescription in Canada for the prescription sent by me and my doctor, and to package and ship the pharmaceutical(s) to my address to the same extent as if I were personally present and signing those documents myself.
7. I understand that the medications provided by Canada Direct Pharmacy Ltd. may not be in child protective packaging.
8. I release and discharge Canada Direct Pharmacy Ltd and its shareholders, officers, directors, agents and affiliates from any and all causes of action, claims or liabilities whatsoever with respect to any possible adverse reactions, the late delivery, non-delivery or missed delivery of the pharmaceutical(s) ordered by me.
9. I acknowledge and agree that the medical doctors and pharmacists utilized as agents by Canada Direct Pharmacy Ltd. solely provide an administrative function in reviewing a valid prescription issued to me by a doctor qualified to practice medicine in the U.S. and that all treatments relating to my general health and the prescription that I will send to Canada Direct Pharmacy Ltd., shall be solely the responsibility of my prescribing doctor.
10. I further acknowledge and agree that any follow-up consultation and related health treatments whether or not related to the prescription that I will deliver to Canada Direct Pharmacy Ltd., are the sole responsibility of my prescribing doctor and that no medical or pharmaceutical agents of Canada Direct Pharmacy Ltd. shall in any way whatsoever be responsible to me in providing any form of follow up medical consultation or treatments.
11. I acknowledge and agree that any and all agreements reached or contracts formed or disputes that arise throughout the course of the relationship between myself and Canada Direct Pharmacy Ltd shall be deemed to be made and be governed by the laws of the Province of Alberta and the laws of Canada as applicable understand that Canada Direct Pharmacy Ltd. shall be entitled to substitute a prescription drug with a generic drug where available unless the physician or I have indicated that there be "no substitution", and that Canada Direct Pharmacy Ltd. have the right not to fill any prescription at its sole discretion and that once purchased and shipped, no pharmaceutical product may be returned or exchanged.
12. Any reference to Canada Direct Pharmacy Ltd. shall include Canada Direct Pharmacy's agents, affiliates, employees, officers, investors and directors.

I have read and understood the foregoing.

Client Signature: _____ Client Name (Printed): _____

City / Town Where Signed: _____ Date Signed: _____