Rxoption

Patient Order Form

E support@rxoption.com

Personal Information

◯ Male ◯ Female

Full Name (please print clearly)

Street Address

City | State/Province | Country | Zip/Postal Code

Phone (Home) | Phone (Other)

E-mail | Birthdate (MM/DD/YY) / /

Best time to be contacted

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

Medication

For medication(s) that you wish to order, please enter the quatity and listed price as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, e-mailed or called in from your doctor.) PRICING IN $US DOLLARS.

Medication	Strength	Qty	Price
		Shipping	
◯ Check box if you do **NOT** want childproof caps.		**TOTAL**	

Payment Options

Please choose **one** of the payment options below.
Note: Personal Checking Accounts are only available for use in the US.

◯ Option 1: **Credit Card**

◯ Visa ◯ MC

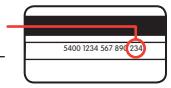
Cardholders's Name

Cardholder's Address

City | State/Province | Country | Zip/Postal Code

Credit Card Number

Credit Card Expiry (MM/YY) / | CVV Code



◯ Option 2: **Personal Checking Account** (Check or EFT) **US Only**

◯ Use my check information "on file"

◯ I will send a VOIDED check by:

- ◯ Fax
- ◯ E-mail
- ◯ Mail (use address below)

◯ I will make a payment by check and mail it to

rxoption.com

First Time Patients

Please fill out this section if you are a first time patient or to update your information

Full Name of Secondary Contact

Relationship to You | Phone Number

Your Primary Physician's Name

Clinic Name, Street Address

City | State/Province | Country | Zip/Postal Code

Phone Number | Ext. | Fax Number

Allergies

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

If yes, please list which drug(s) you are allergic to:

Medication, OTC, Herbal Products you are currently taking:

(only list medications you are not ordering)

Medication	Dosage	Frequency

Patient Authorization (Please Check One)

rxoption.com operates as a pharmacy broker that specializes in assisting international pharmacies provide patient healthcare at a distance. The following terms and conditions govern dealings between you ("You") and the authorized dispensary (the "Pharmacy") regarding the products and services (the "Services") offered by the Pharmacy. You herein represents to the Pharmacy that,

"I, being over the age of majority,

◯ **1.** have fully and accurately disclosed my private health information and consent to its use by the Pharmacy. I have had a face-to-face physical examination by my primary care physician within the last 12 months, and do not require a new examination.

2. I authorize and grant power of attorney to the Pharmacy 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 valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This power of attorney shall include authority to: collect and use my private health information as required 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 but shall continue until I revoke it.

3. I understand that all Services shall be offered from and performed by the Pharmacy in its country of licensure and in a manner consistent with the local laws and regulations applicable to that country.

4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in its home country, and that I am purchasing medications that have been approved for sale within that country. Title to my medications passes from the Pharmacy to me in the country 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 requesting the Services, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on his or her behalf."

Patient's Signature | Date (MM/DD/YY) / /

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Prescription Submission

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

Full Name (please print clearly)

Phone Number | Order Number (if available)

☐ Option 1: **Contact My Doctor** *

Physician's Name

Clinic Name

Street Address

City | State/Province | Country | Zip/Postal Code

Phone Number | Ext. | Fax Number

☐ Option 2: **Transfer From Another Pharmacy** *

Pharmacy Name

Street Address

City | State/Province | Country | Zip/Postal Code

Phone Number | Ext. | Fax Number

* Contacting your doctor and transfering from another pharmacy is only available to residents of the United States.

☐ Option 3: **Mail Your Prescription**

Please mail your prescription and this form to:

Rxoption
16850-112 Collins Avenue
209 Sunny Isles, Fl 33160
United States

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