



New Patient Fax Order Form

Fax to: +1-646-514-4334

Total Number of Pages (including this sheet) _____

Your Name: _____

Email Address _____

1. Complete & sign the attached form

2. Fax +1-646-514-4334 along with a copy of your original Prescription or Copy of Risk Release Form and a copy of a Picture ID.

All prescriptions will be authorized for a 1-year period if indicated by the physician and will be honored from the date on the prescription form. Medication shortages happen from time to time. If you have ordered a medication that is on shortage you will be notified prior to shipping. All prescription drug prices include pharmacy-dispensing fee.

Attach Prescription Here or Fill out the Risk Release form:

Cart Details

Rx- = Prescription Required Rx- = No Prescription Required

Medication 1 _____	Qty _____	\$ _____
Medication 2 _____	Qty _____	\$ _____
Medication 3 _____	Qty _____	\$ _____
Medication 4 _____	Qty _____	\$ _____
Medication 5 _____	Qty _____	\$ _____

Billing Address

First Name: _____

Last Name: _____

Address: _____

City / Town: _____

State / Providence: _____

Zip / Postal Code: _____

Country: _____

Email: _____

Tel: _____

Fax: _____

Shipping Address

First Name: _____

Last Name: _____

Address: _____

City / Town: _____

State / Providence: _____

Zip / Postal Code: _____

Country: _____

Email: _____

Tel: _____

Fax: _____

Payment Method

credit card information.

CC# _____

Type: Visa – Master Card – American Express – Discover (Please circle one)



Expiry Date _____ (MM/YY) Security (3 or 4 Digit Code) _____
We proudly accept: Visa/MC/Amex/Discover

New Patient Questionnaire

If you have previously purchased from Pharmacyave.com, you do not need to fill out the patient questionnaire below.

Personal Information

First Name: _____
Last Name: _____
Sex (M/F): _____
Date Of Birth: _____
Telephone: _____
Alt. Telephone: _____
Best Time To Call: _____

Physician Information

First Name: _____
Last Name: _____
Address: _____
City / Town: _____
State / Providence: _____
Zip / Postal Code: _____
Country: _____
Email: _____
Tel: _____
Fax: _____

Medical History

Drug Allergies:
Major Operations:
Other: Other:
Other Conditions/Comments:

Do you have any of the following Health Conditions?

Yes No Preventative Health

- Mammogram
- Pap
- Prostate Check
- Yearly

Yes No Eye



- Glaucoma
- Macular degeneration
- Cataract
- Ocular Pressures

Yes No **Respiratory**

- Asthma
- COPD
- Emphysema
- Allergies

Yes No **Cholesterol**

- Stable
- Unstable
- Diet Controlled
- LFT

Yes No **Bladder & Kidney**

- Prostate

Yes No **Diabetes**

- Type 1
- Type 2
- Diet controlled
- Insulin
- A1C

Yes No **Thyroid**

- Hormone therapy
- TSH



HRT

Other

Yes No **Musculoskeletal**

Osteoporosis

Arthritis

Back pain

Autoimmune

Fibromyalgia

Yes No **Cancer**

Yes No **Neurological**

Migraine

TIA

TIA

CVA

Neuropathy

Parkinson

Dementia

Seizures

Yes No **Dermatology**

Fungal Infection

Psoriasis

Rosacea

Yes No **Other**

Current Medication

Drug Name / Strength Instructions

(eg. 1/day)

Time Used



(eg. 5 years)
Medical Condition
(eg. high cholesterol)

Terms of Agreement

No prescription(s) will be filled until a signed and dated copy of this document and a completed Patient Profile have been received by Pharmacyave

These documents can be sent by fax to:

+ 1-646-514-4334

AGREEMENT FOR SERVICES

A. DISCLOSURE AND REPRESENTATIONS BY CUSTOMER:

I, the undersigned, acknowledge, represent and confirm to Pharmacyave DBA SKI USA Inc. (hereinafter collectively referred to as "Pharmacyave") that:

The prescription(s) that I submit to Pharmacyave for the medications (referred to in this Agreement as "pharmaceuticals" or "medications") described in the prescription were prescribed by a physician ("My Doctor") licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside or where I sought treatment and who I personally consulted.

The prescription(s) were lawfully obtained by me from My Doctor.

I will continue to have my medical condition and my use of the pharmaceuticals obtained through Pharmacyave monitored by My Doctor on a regular basis as My Doctor may advise me.

I am engaging Pharmacyave for the sole purpose of obtaining prescription medications at a lower price than in the country in which I reside.

I am not seeking medical advice or medical treatment of any kind or nature whatsoever from Pharmacyave or am I relying upon any medical information from Pharmacyave or from any of its employees, officers, agents or any and all others acting through or for Pharmacyave.

I understand that neither Pharmacyave nor any of its employees, officers agents and all others acting through or for it, nor anyone that is acting on its behalf, is providing medical advice, treatment advice or treatment of any kind whatsoever to me.

I will use any pharmaceuticals obtained for me by Pharmacyave strictly according to the instructions provided by My Doctor.

The pharmaceuticals will only be used as directed and only by me.

I can make my own medical decisions according to the law of the place where I reside.

The prescription(s) for the pharmaceuticals has not been altered in any way nor has it been filled prior to submission to Pharmacyave.

I will immediately contact My Doctor in the event that I suffer any side effects from any pharmaceuticals.

It is my responsibility to have regular physical examinations by My Doctor including all testing to ensure that I have no medical problems, which would constitute a contradiction to me taking the pharmaceuticals.

Pharmacyave employees and agents have relied on the information and documentation that I have provided or will provide (including the Patient Profile) and I represent and confirm that I have fully disclosed all pertinent and relevant information and documentation to Pharmacyave. I agree to promptly notify Pharmacyave of any changes to my physical or medical condition by providing an updated Patient Profile.

I hereby authorize and appoint Pharmacyave, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription(s) in India that is the equivalent of the prescription(s) for the Pharmaceuticals that I have forwarded to Pharmacyave, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to Pharmacyave employees, agents and service providers including the Indian physician being retained on my behalf, as required, for the limited purpose of obtaining the Indian prescription. The authorizations and consents that I am providing to Pharmacyave commence on the date I have signed this agreement and shall continue until I revoke them. I understand that I can revoke the consents and authorizations I have granted to Pharmacyave at any time.

I hereby specifically acknowledge that I am aware that Pharmacyave will be transmitting my personal health information by electronic means (for example fax, secure internet) to its affiliates and service providers including the Indian physician retained by Pharmacyave on my behalf to obtain the Indian prescription(s). I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that Pharmacyave, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to Pharmacyave transmission of my personal health information by electronic means.

If I was directed to Pharmacyave services through an affiliate, intermediary or other healthcare service provider Herein called an "Intermediary") I hereby authorize Pharmacyave to release the following data to such intermediary: a numerical identifier indicating that I was a patient referred from that intermediary; financial information that will permit the processing of any claims on my behalf; It is my understanding that all such intermediaries will enter into confidentiality agreements where they will agree to abide by the privacy policies of Pharmacyave relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.

I authorize and appoint Pharmacyave as my agent and attorney for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.

I authorize and appoint Pharmacyave as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceuticals to me as if I had shipped them myself to my own address.



I understand that Pharmacyave is located in India, not in the United States.

I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and Pharmacyave shall be deemed to be made in the State of Maharashtra, India and accordingly shall be governed by the laws of the India.

I agree that any dispute that arises between me and Pharmacyave, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors shall be governed by the laws of the State of Maharashtra and I agree that the courts of the State of Maharashtra shall have sole and exclusive jurisdiction over any such dispute.
If a problem arises,

C. PURCHASE AND SALE TERMS

I hereby acknowledge, understand, authorize and agree that:

Pharmacyave may charge my credit card account or may withdraw funds from my bank account through online checking for the Pharmaceutical (s) price(s) plus shipping (in US Dollars) as is posted on the Pharmacyave web site on the date that Pharmacyave completes my order.

In the event my payment is not authorized, I understand that Pharmacyave has the right to cancel my order. In such event Pharmacyave will attempt to provide me with notice of such cancellation. If my order is cancelled after Pharmacyave has processed my order and before the order goes to the pharmacy there will be a \$20.00 US administration fee. After an order has been sent to the pharmacy I may not cancel the order and the sale is final.

Pharmacyave shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available, unless the physician has indicated that there be "no substitution" or dispensed as written. **ONCE PURCHASED AND SHIPPED, NO PHARMACEUTICAL PRODUCT MAY BE RETURNED OR EXCHANGED.**

Pharmacyave reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund for monies paid for such order. Pharmacyave does not provide its agency or attorney services as a substitute for healthcare or the advice of My Doctor.

Pharmacyave will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription. Pharmacyave shall not accept the return for use or re-use of any portion of any drug or non-prescription medication (Indian College of Pharmacists Bylaw 5 (33 subsection.1)).

I have read and understood all of the terms and conditions set out in this Agreement for Services and agree, on behalf of myself, my heirs, successors, executors, administrators and assigns to be bound by these terms and conditions.

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D. AUTHORIZATION TO INDIAN DOCTOR

I provide my consent and authorize any physician, licensed in India and engaged by Pharmacyave for the purposes set out herein, to obtain my full medical history, drug history, contact information and other necessary information and documentation from my U.S. physician. In this context, I further consent to both the Indian physician and my U.S. physician contacting one another to discuss my medical condition and medical information and to release any such medical information to each other, as such may be necessary or appropriate to the prescribing of medication(s). I understand that the reason for this consent is to provide the Indian physician with a full opportunity to conduct an independent analysis of whether the medication(s) prescribed by my U.S. physician is appropriate, and discuss any potential medical complications that may arise. I further understand that my medical information will not be used for any other reason, and will be kept in strict confidence.

I further agree to regularly visit my U.S. physician(s) and to promptly advise the Indian physician of any changes to my medical condition or prescriptions.

I have read and understood the terms and conditions set out in this AUTHORIZATION TO INDIAN DOCTOR above and I agree, on behalf of myself, my heirs, executors, administrators, successors and assigns to be bound by these terms and conditions.

Signed this ____ day of _____, 20____.

(Signature)

Print Name Clearly: _____

**Incase No Prescription Is provided Please Also
Fill the Risk Release Form and Fax Along with the
Above Details.**



Thank you for placing your order with Pharmacyave.com

In order to expedite your order quick, we need you to sign (electronically) or Print and Sign and Fax back +1 646-514-4334

_____(Initial) I have obtained or will obtain a Prescription for the Medicines ordered form Pharmacyave.com. We understand the risk and Liability of the medicines ordered.

_____(Initial) I do not hold Pharmacyave.com or any of its affiliates liable for any damages or losses incurred to myself or surroundings.

_____(Initial) I have you had a physical exam in the last 12 months and my Personal Health Practitioner is aware I am taking these drugs.

_____(Initial) I/we understand that Pharmacyave is a concierge service and not Pharmacy. Pharmacyave is not reselling medicine but providing a service at fees that include the cost of product, local management, shipping and handling.

My current order is: _____ Medicine.

Sign

Print Name

Date

Thank you,

Orders Dept
www.Pharmacyave.com