## **Rx Card Services**

 Phone:
 1-866-266-9955

 Fax:
 1-855-716-9505

 Email:
 info@ecprx.com

Full Name (please print clearly)       Male         Full Name (please print clearly)       Female         City       State/Province       Country       Zip/Postal Code         Phone (Hime)       Phone (Other)       /       Image: Code       Image: Code         Please check if you are placing this order for a pet.       /       Image: Code       Image: Code       Image: Code         Please check if you are placing this order for a pet.       /       Image: Code       I	Personal Information			Med	ication				
In Human, proceed print clearly ()       ()<					For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained				
City       State/Province       Country       Zip/Postal Code         Phone (Home)       Phone (Other)       /         Email       Birthdate (MM/DD/YY)         Agent Code       Please check if you are placing this order for a pet.         Cat       Dog Other (Please specify)         Would you like to receive a call to remind you of future refilis?       Yes No         Personal Checking Account USA/Canada Only         Cardholder's Address       Cardholder's Address         City       State/Province       Country         Zip/Postal Code       Visa (Mater Card (We do not accept Discover or American Express)       Cordholder's Address         Cardholder's Address       Country       Zip/Postal Code       Rx Card Services         City       State/Province       Country       Zip/Postal Code       Rx Card Services         City       State/Province       Country       Zip/Postal Code       Rz Card Services         City       State/Province       Country       Zip/Postal Code       Winnipeg, Manitoba         R2J 4G7       Canada       R2J 4G7       Canada	· · ·		C Female						
(_)       (_)         Phone (Home)       Phone (Other)         Email       Birthdate (MM/DD/YY)         Agent Code       Image: Code         Please check if you are placing this order for a pet.       Image: Code         Cat O Dog Other (Please specify)       Image: Code         Would you like to receive a call to remind you of future refills?       Yes O No         Eradit Card Options       ShiPPING:         Cardholder's Address       FREE         City       State/Province       Country         Zip/Postal Code       Winnipeg, Manitoba         Credit Card Expiry (MM/YY)       CW Code	Street Address			GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE	
Email       Birthdate (MM/DD/YY)         Agent Code       Please check if you are placing this order for a pet.         Cat O Dg O Uther (Please specify)	City State/Province	Country ( )	Zip/Postal Code						
Agent Code   Please check if you are placing this order for a pet.   Cat Dog   Other (Please specify)     Would you like to receive a call to remind you of future refills?   Yes   No     Payment Options   Credit Card   Cardholder's Name   Cardholder's Name   Cardholder's Name   Cardholder's Name   City   State/Province   Country   Zip/Postal Code   VW Code    OR Personal Checking Account USA/Canada Only Clit limit to Rx Card Services 24 Terracon Place Winnipeg, Manitoba R2J 4G7 Canada	Phone (Home)	Phone (Other)	/						
Please check if you are placing this order for a pet.   Cat   Og   Would you like to receive a call to remind you of future refills?   Yes   No     SHIPPING:   FREE   TOTAL:     Payment Options   Credit Card   Cardholder's Name   Cardholder's Name   Cardholder's Name   Cardholder's Name   City   State/Province   County   Zip/Postal Code   Visa   Visa   Credit Card Number   Credit Card Number   Credit Card Number   Credit Card Spirit (MW/YY)   Credit Card Spirit (MW/YY)    Credit Card Expirit (MW/YY)      City        State/Province              City <b>City State/Province County City Code City Code City Code</b>	Email	Birthdate (MM/DD	YY)						
Cat Dog Other (Please specify)     Would you like to receive a call to remind you of future refills? Yes     No     SHIPPING:     FREE     TOTAL:     Payment Options     Credit Card     Visa     MasterCard     (We do not accept Discover or American Express)     Cardholder's Name     Cardholder's Name     City   State/Province   Country   Zip/Postal Code   Credit Card Number   /   /   Credit Card Expiry (MM/YY)   CW Code	Agent Code								
Would you like to receive a call to remind you of future refills?       Yes       No       SHIPPING:       FREE         Depression Options         Credit Card       Visa       MasterCard (We do not accept Discover or American Express)       OR       Personal Checking Account       USA/Canada Only         Cardholder's Name       I will make a payment by check, and mail it to       Rx Card Services       24 Terracon Place       Winnipeg, Manitoba         Credit Card Number       /       CVV Code       CVV Code       CVV Code       Vinnipeg, Manitoba									
TOTAL:         TOTAL:         Cardholder's Name       OR       Personal Checking Account Us/Canada Only         Cardholder's Name       I will make a payment by check, and mail it to         Cardholder's Address       Rx Card Services 24 Terracon Place Winnipeg, Manitoba R2J 4G7 Canada					SHIPPING: FREE				
Credit Card Visa MasterCard (We do not accept Discover or American Express)   Cardholder's Name Image: Cardholder's Address   Cardholder's Address Country   City State/Province   Credit Card Number   /   Credit Card Expiry (MW/YY)   Credit Card Expiry (MW/YY)   CVV Code OR Personal Checking Account Us/Vanada Only I will make a payment by check, and mail it to Rx Card Services 24 Terracon Place Winnipeg, Manitoba R2J 4G7 Canada					TOTAL:				
Credit Card Visa MasterCard (We do not accept Discover or American Express)   Cardholder's Name Image: Cardholder's Address   Cardholder's Address Country   City State/Province   Credit Card Number   /   Credit Card Expiry (MW/YY)   Credit Card Expiry (MW/YY)   CVV Code OR Personal Checking Account Us/Vanada Only I will make a payment by check, and mail it to Rx Card Services 24 Terracon Place Winnipeg, Manitoba R2J 4G7 Canada									
Cardholder's Name       I will make a payment by check, and mail it to         Cardholder's Address       I will make a payment by check, and mail it to         City       State/Province       Country       Zip/Postal Code         Credit Card Number       Zip/Postal Code       Winnipeg, Manitoba         /       Credit Card Expiry (MM/YY)       CVV Code		at account Discover or Ame	ricon Evergood)	OD Parso	anal Checking Account				
Cardholder's Address       City       State/Province       Country       Zip/Postal Code       Rx Card Services       24 Terracon Place         Credit Card Number       /       Credit Card Expiry (MM/YY)       CVV Code       Winnipeg, Manitoba		INT ACCEPT DISCOVER OF AME	rican Express)	UR USA/Can	ada Only				
City     State/Province     Country     Zip/Postal Code     24 Terracon Place       Credit Card Number     /     R2J 4G7 Canada       /     Credit Card Expiry (MM/YY)     CVV Code	Cardholder's Name				ill make a payment by check, and mai	il it to			
City     State/Province     Country     Zip/Postal Code     Winnipeg, Manitoba       Credit Card Number     /     R2J 4G7 Canada       /     Credit Card Expiry (MM/YY)     CVV Code	Cardholder's Address								
Credit Card Number / Credit Card Expiry (MM/YY) CVV Code	City State/Province	Country	Zip/Postal Code	_					
	Credit Card Number				1 0				
First Time Patients please fill out this section if you are a first time patient, or to update your information. Patient Authorization (Please Check One)	Credit Card Expiry (MM/YY)		CVV Code						
First Time Patients please fill out this section if you are a first time patient, or to update your information. Patient Authorization (Please Check One)									
Secondary Contact Universal Fulfillment <sup>™</sup> operates a marketing and call centre business in Winnipeg,		n if you are a first time pa	tient, or to update your information		-	-	o in Winninga		
Secondary Contact Universal Fulfillment <sup>™</sup> operates a marketing and call centre business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacy. The following terms and conditions	Secondary contact			Ma	nitoba, Canada, specializing in the busine	ss of assisting pharmad	ies both within C		
Full Name of Secondary Contact govern the sales as between the Universal Fulfillment m <sup>*</sup> authorized dispensary (the "Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the	Full Name of Secondary Contact	( )		ind	ividual (the "Patient") regarding the produ	icts and services (the "F			
Relationship To You Phone Number	Relationship To You Phone Number				"I am over the age of majority, and:				
Your Physician 1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy. I have had a physical examination by a physician within the last 12	Your Physician			1.1	have fully and accurately disclosed my pe				
Primary Physician's Name	Primarv Physician's Name			mo	nths, and do not require a physical examin	ation.			
Clinic Name, Street Address									
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 (a)	·	Country	7:p/Destal Cada	and	I to act on my behalf as if I were personally	<pre>present and acting my</pre>	self for the limite	d purposes of (a)	
City       State/Province       Country       Zip/Postal Code       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:         Phone Number       Evt       Fay Number       collecting and using my personal and personal health information as reasonably necessary for the	<u>(</u> )	( )	ZIP/Postal Code	my	my prescriptions and delivering them to me. This authorization shall include, but not be limited to:				
fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid		Fax Number		fulf	illment of my order, including disclosure to	a licensed physician if	required for the is	ssuance of a valid	
Allergies Do you have any known drug allergies? Yes No If yes, please enter the drug(s) you are allergic to: 4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business		If yes, please enter the	drug(s) you are allergic to:			accorporated and author	zad by law to carr	v on husinoss	
4. Inderstand that there in the plant incorporate and autorized by the using medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in				int	he jurisdiction of the Pharmacy, and that I	am purchasing medica	tions that have be	en approved	
Medication, OTC, Herbal Products You Are Currently Taking 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				the	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				
jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising	·	DOSAGE	FREQUENCY	juri	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				I H.	WE READ AND UNDERSTAND THESE TERMS	AND AGREE THAT THEY	SHALL BE BINDIN	IG UPON ME AND	
MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."					MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."				
"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."				(°] a	"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				
					r auent S Dellan.				
	Deferred Drogram (							/ /	
Referral Program (complete to earn credits for yourself and the person who referred you) Date (MM/DD/YY)	Referral Frogram (complete to earn credits for	r yourself and the pers	on who reterred you)		<ul> <li>Patient's Signature</li> </ul>			Date (MM/DD/YY)	
Full Name of person who referred you         Phone Number         PSC:         MKT:         WEB         AFF:         RCS-100	Full Name of person who referred you	Phone Number		PSC:	MKT: W	EB	AFF: RCS	-100	