HealthWarehouse.com℠
America's Trusted Online Pharmacy

Patient Order Form

Phone:	Fax:	Internet:
800-748-7001	888-870-2808	www.HealthWarehouse.com

Mailing Address: 7107 Industrial Rd, Florence, KY 41042

Personal Information

This section is for the person filling out this form.

Full Name (please print clearly)

Street Address

City | State | Zip

( ) Phone (Home) | ( ) Phone (Other)

Email | Birthdate (MM/DD/YY)

Please check if you are placing this order for a pet.
○ Cat ○ Dog ○ Other (Please specify) _____

Medication

For medication(s) that you wish to order, please enter the quantity and the listed price (as obtained through our website or customer sevice center). An original prescription from your doctor's office is required (mailed, called, e-script, or faxed in from your doctor).

GENERIC Y/N	MEDICATION	STRENGTH	QTY	PRICE

○ Subscribe to monthly newsletter for FREE SHIPPING (normally $3)

SHIPPING (SEE REVERSE):

TOTAL USD:

Payment Option

Pay by Credit or Debit Card

Cardholder's Name

Cardholder's Address

City | State | Zip

Credit Card Number | Expiration Date (MM/YY)

Pay by Check

USA Only

○ I will make a payment by check, and mail it to:
7107 Industrial Rd, Florence, KY 41042

Note: Paying by check can extend your processing time by 3-5 days.

Patient Information

This section is for the person taking the medication.

Patient's Full Name | Patient's Birthdate (MM/DD/YY)

Patient's SSN or Driver's License Number (if ordering controlled substance)

Primary Physician's Name

Clinic Name, Street Address

City | State | Zip

( ) Phone Number | Ext. | ( ) Fax Number

○ Male
○ Female
Are you pregnant? ○ Yes ○ No

○ Check box if you **DO NOT** want childproof caps
○ Check box to be counseled on your medications

Allergies

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

If yes, please enter the drug(s) you are allergic to:

Medical Conditions

○ None Known	○ Heart Disease	○ Septicemia
○ Alzheimers	○ Influenza	○ Carebrovascular Disease
○ Cancer	○ Kidney Disease	○ Chronic Lower Respiratory Disease
○ Diabetes	○ Pneumonia	○ Other: _____

Medications, OTC, Herbal Products You Are Currently Taking

MEDICATION *(only list medications you are not ordering)*	DOSAGE	FREQUENCY

Patient Authorization (Please Check One)

The following terms and conditions govern the sales between HealthWarehouse.com™ authorized dispensary (the "Pharmacy") and the individual (the "Patient") regarding the products and services ("the Products") offered for sale by the Pharmacy. The patient herein represents to the Pharmacy that:

○ I am over the age of majority, and:

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 months and do not require a physical examination.
2. I understand that all Products shall be sold and dispensed by a Pharmacy operating within the Kentucky Board of Pharmacy jurisdiction and in a manner consistent with the laws of the United States of America.
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) obtaining a valid prescription for any prescription which I have sent to the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary 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 and shall continue until I revoke it.
4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been FDA approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in 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 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 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.

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

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Prescription Submission

Phone:	Fax:	Internet:
800-748-7001	888-870-2808	www.HealthWarehouse.com

Mailing Address: 7107 Industrial Rd, Florence, KY 41042

How long does it take to process my prescription?

It depends on how quickly we receive your prescription from your doctor or pharmacy. Once a valid, legal prescription is received, you should expect 1-3 days of processing time, though our average is around 24 hours.

What are your shipping rates?

USPS Standard Ground Shipping - $3 or FREE if you opt-in to our monthly newsletter - 2-8 business day
USPS/UPS Signature Confirmation - $3.95 - 2-8 business days; **STRONGLY RECOMMENDED**
USPS Priority - $10 - 1-3 business days
UPS Tracking - $11.95 - 1-5 business days
UPS 2-Day - $17.95 - 2 business days
UPS Next Day Air - $29.95 - 1 business day

◯ Option 1: Doctor Will E-Scribe/Call/Fax *

Ask your doctor to send your prescription to HealthWarehouse.com:

- **By E-Script**
- **By Phone:** 1-800-748-7001
- **By Fax:** 1-888-870-2808

◯ Option 2: Transfer from Another Pharmacy *

Pharmacy Name

Street Address

City | State | Country | Zip

( ) Phone Number | Ext. | ( ) Fax Number

Please list the medications that will be faxed from your doctor, or to be transferred from another pharmacy.

MEDICATION	STRENGTH	WILL RX BE FAXED OR TRANSFERRED?	RX NUMBER

* A fax from your doctor, and transferring from another pharmacy is only available to residents of the United States

◯ Option 3: I Will Mail My Prescription

Please mail your prescription and this form to:

HealthWarehouse.com
7107 Industrial Rd
Florence, KY 41042

Your Next Steps

1 Contact your doctor

Have your doctor send us your prescription via e-script, phone, or fax. The sooner we receive your prescription, the sooner we'll ship your medication.

2 Your order will process

You should expect 1-3 business days of processing time, though this may be longer or shorter depending on how soon we hear from your doctor.

3 You'll receive your meds

You'll receive your package within 1-8 business days depending on the shipping method selected.