PATIENT ORDERING FORM

HealthWarehouse

Personal Information

Full Name | Birthday (MM/DD/YYYY))

If this order is for a pet, please specify: ○Cat ○Dog ○Other _____

Street Address | City | State | Zip

Phone | Email

Patient Information

This section is for the individual taking the medication.

Full Name | Birthday (MM/DD/YYYY))

Patient's SSN or Driver's License Number (controlled substances only)

○Male ○Female
Gender at Birth

Prescribers Name | Office Address

City | State | Zip

Prescriber's Phone Number | Prescriber's Fax Number

- ○ ***I do NOT want childproof caps on my bottles.***
- ○ ***I want to be counseled on my medications by a pharmacist.***
- ○ ***I am pregnant.***

List any known drugs allergies & medical conditions here:

List any prescription medications, Over-the-Counter products, or herbal products you are currently taking here:

Payment Information

Cardholder Name | Security Code/CVV

Credit Card Number | Expiration Date (MM/YY)

Billling Address

City | State | Zip

○ *Billing Address is the same as Shipping Address*

Medication

Please enter the name, strength, and quantity of medication you'd like to order.
An original prescription from your prescriber is required.

MEDICATION	STRENGTH	QUANTITY	GENERIC (Y/N)

Shipping

○ FREE - 2-8 Business Days *By selecting this, you are opting in to receive weekly emails.*
○ Standard $5.00 - 2-8 Business Days
○ Expedited $10.00 - 1-3 Business Days
○ 2 day $15.00 - 2 Business Days
○ Overnight $25.00 - 1 Business Day

Prescription Information

- ○ ***I will mail the original prescription in.***
- ○ ***My prescriber will send it in (via phone, fax, or E-Script.)***
- ○ ***I will need it transferred from another pharmacy.***

Pharmacy Name | Phone Number

Address

City | State | Zip

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 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 jurisdication of the Pharmacy, and that I am purchasing medication that have been FDA approved for sale in the jurisidiction of the Pharmacy. Title to my medications passes from the agreements reached or contracted formed with the Pharmacy when my medications passes from the 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 an 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 to the Patient's behalf.

X _____

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

1-800-748-7001 | 1-888-870-2808 | 7107 Industrial Road Florence, KY 41042