Digital Prescription Service

To Register, Carefully Follow These 2 Easy Steps!

1. **Registration Form**

   Fill out the attached Registration Form in Full. This **must** include: your Physicians name, complete contact Information, your preferred method of payment your local pharmacy and current shipping address.

2. **Prescriptions**

   Maximize your savings, ask your Doctor to write you a 3 month supply with 3 refills. To speed up the processing of your order, your doctor can fax prescriptions to **905-948-0464** directly from his office. Faxed prescriptions can **only** be accepted when faxed directly from your Doctors office.

   Alternatively, you may send any **original** prescriptions along with all completed paperwork to us through regular post or courier and they will be processed immediately upon their arrival. If you are located near our vicinity and want to pick up your order we welcome you to stop in and personally drop off your prescriptions.

Registration Checklist

To ensure there are no delays in processing your first order, please ensure that **all** of the following necessary paperwork is sent together.

☑ Registration Form - Completed
☑ Medical Summary - Completed
☑ Prescriptions From Your Doctor

Orders that do not contain all of the above paper work will experience a delay in processing until all paperwork is complete

Additional Ordering Information

- Shipping plus insurance ranges from $7.00- $14.00 are waived for orders of $50.00 or more.
- Copayment may be charged to your Credit Card. If you are using our E-cheque debit service, please fill-out the Authorization for E-cheque Debit Forms.
- Certain medications are not suitable for shipping

ADV-CARE Pharmacy 195 Riviera Dr. Unit 2, Markham, Ont. L3R 5J6
Telephone: (905) 948-1991 Toll-Free:(888) 471-4721 Fax: (877) 948-0464

Digital Prescription Service
Registration Form

Personal Information:

Last Name	First Name	Group LOC	Birth Date DD/MM/YYYY	Gender ☐ Male ☐ Female

Contact Information:

Address	City	Province	Postal Code
Home Phone	Fax	Email	
Preferred Contact Phone/Cell #			

Medical Information:

Medications Currently Prescribed

Allergies: ☐ No, known allergies ☐ Yes, please specify:

Allergy (drug), reaction?

Medical Conditions (please check)

☐ Pregnancy ☐ Asthma ☐ Hypertension ☐ Bleeding Disorder ☐ Diabetes
☐ Glaucoma ☐ Cholesterol ☐ Heart Condition ☐ Arthritis ☐ Other:

RX Refill Options: ☐ Refill by Email ☐ Refill by Phone

Accept Generic Substitute: ☐ Yes ☐ No

Your Family Doctor Information: ☐ Pharmacy Calls For Rx ☐ Doctor Fax/Phone/Mail Rx

Dr. Last Name	Dr. First Name	Phone	Fax
Dr. Address	City	Province	Postal Code

Shipping Information: (required if different than contact information above)

Shipping Address	City	State/Prov.	Zip/P.Code	Country

* Shipping Insurance may be charged for orders above $100 Dollars

Insurance Information (please check):

☐ Emergis (Assure) ☐ Blue Cross ☐ Green Shield ☐ ClaimSecure ☐ ESI
☐ Manulife ☐ Indian Affairs ☐ Other:

Group No.	Member ID No.

☐ Primary Card Holder ☐ Spouse ☐ Dependent

Your Local Pharmacy Contact Info:

Pharmacy Name	Tel. Number	Fax Number

Method of Payment (out of pocket - check only one):

☐ Cash(COD) ☐ Visa ☐ Mastercard ☐ Wire ☐ E-check

Card Holder Name (on card)	Card Number	Expiration (MM/YY)	CVD

By signing below, I authorize and consent to ADV-CARE Pharmacy Inc.: (i) collecting and checking the accuracy of the personal and the personal health information I have provided and will be providing in the future; (ii) disclosing the information to third parties so that such third parties may provide verification of such personal information to them from information they have previously collected about me; (iii) using the information to fill my prescriptions and to collect payment (iv) disclosing the information to other pharmacies to whom my prescriptions may be transferred or who may assist them in filling my prescriptions; and (v) keeping my information on their premises or the premises of pharmacies to whom my prescriptions are transferred or who are assisting them; (vi) transfer any of my prescriptions to my local pharmacy or a pharmacy of their choice, (vii) recieve electronc communications from ADV-Care Pharmacy by phone, e-mail, SMS, fax or any communication means or (viii) retain another pharmacy to assist them to centrally fill my prescriptions. I acknowledge that ADV-CARE Pharmacy's collection and use of my information is subject to their privacy policy which is available at https://www.advpharmacy.com/privacy-policy/ or which can be obtained by calling this number 1-888-471-4721. Due to the nature of the products,

Signature: ____________________ **Date:** ____________________

Fax to: **905**-948-0464

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