Brand-name International Mail-order

Phone: 855-633-7977
Fax: 862-242-5649
Email: scriptupload@medaffordglobal.com

How To Order

Step 1. Complete entire form

Step 2. Return form via Fax or Email

Step 3. Call 855-633-7977

Personal Information

Full Name (please print clearly)

Street Address

City State/Province Zip/Postal Code

( )
Phone

Email Birthdate (MM/DD/YY)

Rx Group

The Rx Group can be found on the back of the card and / or on the MedAfford Global website at the top of the Drug Pricing or Order pages. Ex: ABC1234

Rx Group: _____

Current Order

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained from www.medaffordglobal.com or the customer service center. A valid prescription is required (mailed, emailed or faxed). PRICING IN $ US DOLLARS.

PHARMACY COUNTRY	MEDICATION	STRENGTH	QTY	Refill	PRICE
				⬭	
				⬭	
				⬭	
				⬭	
				⬭	
			Shipping: Canadian Pharmacy $9.50; All other pharmacies are FREE		
				TOTAL:	

For Refills only: If you are refilling a medication through MedAfford Global and do not wish to receive a phone call, please initial here: _____

Payment Options

Credit Card

Cardholder's Name

Cardholder's Address

City State/Province Country Zip/Postal Code

Credit Card Number

/
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.

Your Physician

Primary Physician's Name

Clinic Name, Street Address

City State/Province Country Zip/Postal Code

( ) ( )
Phone Number Ext. Fax Number

Allergies

Do you have any known drug allergies? ⬭ **Yes** ⬭ **No** If yes, please enter the drug(s) you are allergic to:

Medication, OTC, Herbal Products You Are Currently Taking

(only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

Authorization (Please check all):

⬭ 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 for my medication order. 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 & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.

⬭ 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 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 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.

⬭ 5. I understand that, by law, I am unable to return any medication for any reason.

⬭ 6. I understand that once my order has been placed, I cannot receive a refund for the priced amount of medications on my order.

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 on the Patient's behalf.

⬭ I have read and agree to the Terms and Conditions for this program listed above.

⬭ I authorize NBBI Signup to deduct the cost of the brand-name medication(s) selected.

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