

New Patient Fax Order Form

Fax to: +1 917-591-9249

Total Number of Pages (including this sheet) _____

Your Name: _____

Email Address _____

1. Complete & sign the attached form
2. Fax +1-917-591-9249 along with a copy of your original Prescription or Copy of Risk Release Form and a copy of a Picture ID.

All prescriptions will be authorized for a 1-year period if indicated by the physician and will be honored from the date on the prescription form. Medication shortages happen from time to time. If you have ordered a medication that is on shortage you will be notified prior to shipping. All prescription drug prices include pharmacy dispensing fee.

Attach Prescription Here or Fill out the Risk Release form :

Cart Details

Rx- = Prescription Required **Rx- = No** Prescription Required

Medication 1	_____	_____	Qty	_____	\$	_____
Medication 2	_____	_____	Qty	_____	\$	_____
Medication 3	_____	_____	Qty	_____	\$	_____
Medication 4	_____	_____	Qty	_____	\$	_____
Medication 5	_____	_____	Qty	_____	\$	_____

Billing Address

First Name: _____
 Last Name: _____
 Address: _____
 City / Town: _____
 State / Providence: _____
 Zip / Postal Code: _____
 Country: _____
 Email: _____
 Tel: _____
 Fax: _____

Shipping Address

First Name: _____
 Last Name: _____
 Address: _____
 City / Town: _____
 State / Providence: _____
 Zip / Postal Code: _____
 Country: _____
 Email: _____
 Tel: _____
 Fax: _____

Payment Method

credit card information.

CC# _____

Type: Visa – Master Card – American Express – Discover (Please circle one)

Expiry Date _____ (MM/YY) Security (3 or 4 Digit Code) _____

We proudly accept: Visa/MC/Amex/Discover

New Patient Questionnaire

If you have previously purchased from Shopeastwest.com, you do not need to fill out the patient questionnaire below.

Personal Information

First Name: _____
Last Name: _____
Sex (M/F): _____
Date Of Birth: _____
Telephone: _____
Alt. Telephone: _____
Best Time To Call: _____

Physician Information

First Name: _____
Last Name: _____
Address: _____
City / Town: _____
State / Providence: _____
Zip / Postal Code: _____
Country: _____
Email: _____
Tel: _____
Fax: _____

Medical History

Drug Allergies:
Major Operations:
Other: Other:
Other Conditions/Comments:

Do you have any of the following Health Conditions?

Yes No **Preventative Health**

- Mammogram
- Pap
- Prostate Check
- Yearly

Yes No **Eye**

- Glaucoma
- Macular degeneration
- Cataract
- Ocular Pressures

Yes No **Respiratory**

- Asthma
- COPD
- Emphysema
- Allergies

Yes No **Cholesterol**

- Stable
- Unstable
- Diet Controlled
- LFT

Yes No **Bladder & Kidney**

- Prostate

Yes No **Diabetes**

- Type 1
- Type 2
- Diet controlled
- Insulin
- A1C

Yes No **Thyroid**

- Hormone therapy
- TSH
- HRT
- Other

Yes No **Musculoskeletal**

- Osteoporosis
- Arthritis
- Back pain
- Autoimmune
- Fibromyalgia

Yes No **Cancer**

Yes No **Neurological**

- Migraine
- TIA
- CVA
- Neuropathy
- Parkinson
- Dementia

Seizures Yes No **Dermatology**

-
- Fungal Infection
-
-
- Psoriasis
-
-
- Rosacea

 Yes No **Other**

Current Medication

Drug Name / Strength Instructions

(eg. 1/day)

Time Used

(eg. 5 years)

Medical Condition

(eg. high cholesterol)

Terms of Agreement

No prescription(s) will be filled until a signed and dated copy of this document and a completed Patient Profile have been received by Shopeastwest

These documents can be sent by fax to:

+1 917-591-9249

AGREEMENT FOR SERVICES

A. DISCLOSURE AND REPRESENTATIONS BY CUSTOMER:

I, the undersigned, acknowledge, represent and confirm to Shopeastwest DBA SKI USA Inc. (hereinafter collectively referred to as "Shopeastwest") that:

The prescription(s) that I submit to Shopeastwest for the medications (referred to in this Agreement as "pharmaceuticals" or "medications") described in the prescription were prescribed by a physician ("My Doctor") licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside or where I sought treatment and who I personally consulted.

The prescription(s) were lawfully obtained by me from My Doctor.

I will continue to have my medical condition and my use of the pharmaceuticals obtained through Shopeastwest monitored by My Doctor on a regular basis as My Doctor may advise me.

I am engaging Shopeastwest for the sole purpose of obtaining prescription medications at a lower price than in the country in which I reside.

I am not seeking medical advice or medical treatment of any kind or nature whatsoever from Shopeastwest or am I relying upon any medical information from Shopeastwest or from any of its employees, officers, agents or any and all others acting through or for Shopeastwest.

I understand that neither Shopeastwest nor any of its employees, officers agents and all others acting through or for it, nor anyone that is acting on its behalf, is providing medical advice, treatment advice or treatment of any kind whatsoever to me.

I will use any pharmaceuticals obtained for me by Shopeastwest strictly according to the instructions provided by My Doctor.

The pharmaceuticals will only be used as directed and only by me.

I can make my own medical decisions according to the law of the place where I reside.

The prescription(s) for the pharmaceuticals has not been altered in any way nor has it been filled prior to submission to Shopeastwest.

I will immediately contact My Doctor in the event that I suffer any side effects from any pharmaceuticals.

It is my responsibility to have regular physical examinations by My Doctor including all testing to ensure that I have no medical problems which would constitute a contradiction to me taking the pharmaceuticals.

Shopeastwest employees and agents have relied on the information and documentation that I have provided or will provide (including the Patient Profile) and I represent and confirm that I have fully disclosed all pertinent and relevant information and documentation to Shopeastwest. I agree to promptly notify Shopeastwest of any changes to my physical or medical condition by providing an updated Patient Profile.

I hereby authorize and appoint Shopeastwest, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription(s) in India that is the equivalent of the prescription(s) for the pharmaceuticals that I have forwarded to Shopeastwest, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to Shopeastwest employees, agents and service providers including the Indian physician being retained on my behalf, as required, for the limited purpose of obtaining the Indian prescription. The authorizations and consents that I am providing to Shopeastwest commence on the date I have signed this agreement and shall continue until I revoke them. I understand that I can revoke the consents and authorizations I have granted to Shopeastwest at any time.

I hereby specifically acknowledge that I am aware that Shopeastwest will be transmitting my personal health information by electronic means (for example fax, secure internet) to its affiliates and service providers including the Indian physician retained by Shopeastwest on my behalf to obtain the Indian prescription(s). I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that Shopeastwest, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to Shopeastwest transmission of my personal health information by electronic means.

If I was directed to Shopeastwest services through an affiliate, intermediary or other healthcare service provider Herein called an "intermediary") I hereby authorize Shopeastwest to release the following data to such intermediary: a numerical identifier indicating that I was a patient referred from that intermediary; financial information that will permit the processing of any claims on my behalf;

It is my understanding that all such intermediaries will enter into confidentiality agreements where they will agree to abide by the privacy policies of Shopeastwest relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.

I authorize and appoint Shopeastwest as my agent and attorney for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.

I authorize and appoint Shopeastwest as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceuticals to me as if I had shipped them myself to my own address. I understand that Shopeastwest is located in India, not in the United States.

I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and Shopeastwest shall be deemed to be made in the State of Maharashtra, India and accordingly shall be governed by the laws of the India.

I agree that any dispute that arises between me and Shopeastwest, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors shall be governed by the laws of the State of Maharashtra and I agree that the courts of the State of Maharashtra shall have sole and exclusive jurisdiction over any such dispute. If a problem arises,

C. PURCHASE AND SALE TERMS

I hereby acknowledge, understand, authorize and agree that:

Shopeastwest may charge my credit card account or may withdraw funds from my bank account through online checking for the Pharmaceutical (s) price(s) plus shipping (in US Dollars) as is posted on the Shopeastwest web site on the date that Shopeastwest completes my order.

In the event my payment is not authorized, I understand that Shopeastwest has the right to cancel my order. In such event Shopeastwest will attempt to provide me with notice of such cancellation. If my order is cancelled after Shopeastwest has processed my order and before the order goes to the pharmacy there will be a \$20.00 US administration fee. After an order has been sent to the pharmacy I may not cancel the order and the sale is final.

Shopeastwest shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available, unless the physician has indicated that there be "no substitution" or dispensed as written. ONCE PURCHASED AND SHIPPED, NO PHARMACEUTICAL PRODUCT MAY BE RETURNED OR EXCHANGED.

Shopeastwest reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund for monies paid for such order. Shopeastwest does not provide its agency or attorney services as a substitute for healthcare or the advice of My Doctor.

Shopeastwest will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription. Shopeastwest shall not accept the return for use or re-use of any portion of any drug or non-prescription medication (Indian College of Pharmacists Bylaw 5 (33 subsection.1)).

I have read and understood all of the terms and conditions set out in this Agreement for Services and agree, on behalf of myself, my heirs, successors, executors, administrators and assigns to be bound by these terms and conditions.

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D. AUTHORIZATION TO INDIAN DOCTOR

I provide my consent and authorize any physician, licensed in India and engaged by Shopeastwest for the purposes set out herein, to obtain my full medical history, drug history, contact information and other necessary information and documentation from my U.S. physician. In this context, I further consent to both the Indian physician and my U.S. physician contacting one another to discuss my medical condition and medical information and to release any such medical information to each other, as such may be necessary or appropriate to the prescribing of medication(s). I understand that the reason for this consent is to provide the Indian physician with a full opportunity to conduct an independent analysis of whether the medications(s) prescribed by my U.S. physician is appropriate, and discuss any potential medical complications that may arise. I further understand that my medical information will not be used for any other reason, and will be kept in strict confidence.

I further agree to regularly visit my U.S. physician(s) and to promptly advise the Indian physician of any changes to my medical condition or prescriptions.

I have read and understood the terms and conditions set out in this AUTHORIZATION TO INDIAN DOCTOR above and I agree, on behalf of myself, my heirs, executors, administrators, successors and assigns to be bound by these terms and conditions.

Signed this ____ day of _____, 20 ____.

(Signature)

Print Name Clearly: _____

**Incase No Prescription Is provided Please Also
Fill the Risk Release Form and Fax Along with the
Above Details.**



SAVE UPTO 80% BUY DIRECT FROM THE SOURCE

Thank you for placing your order with Shopeastwet.com

In order to expedite your order quick, we need you to sign (electronically) or Print and Sign and Fax back +1 9175919249.

_____(initial) I have obtained or will obtain a Prescription for the Medicines ordered form Shopeastwest.com. We understand the risk and Liability of the medicines ordered.

_____(initial) I do not hold Shopeastwest.com or any of its affiliates liable for any damages or losses incurred to myself or surroundings.

_____(initial)I have you had a physical exam in the last 12 months and my Personal Health Practitioner is aware I am taking these drugs.

____(initial) I/we understand that Shopeastwest is a concierge service and not Pharmacy. Shopeastwest is not reselling medicine but providing a service at fees that include the cost of product, local management, shipping and handling.

My current order is: _____ Medicine.

Sign

Print Name

Date

Thank you,

Orders Dept
www.shopeastwest.com