



213 LaBree Ave. N, Suite 102 Thief River Falls, MN 56701
Toll Free Phone: 1-877-223-1886 or Toll Free Fax: 1-877-536-2004

How to Order your medications from Canada.



Order via the Drop Box

1. Complete the order form available [here](#).
2. Once the order form has been completed drop off your original prescription along with the order form and method of payment in the drop box located at the following address:

Canada Discount Healthcare
213 LaBree Ave. N Suite 102
Thief River Falls, MN
56701



Order by Phone

3. Call our Toll-Free customer service line at 1-877-223-1886 to speak with one of our friendly customer service representatives.
4. If this is your first order the customer service agent will request information from you to complete your customer profile, and medical profile.
5. Once this information has been supplied the customer service agent will then take the details of your order (medications wanting to order).
6. To complete your order you must mail or drop off your original prescription to Canada Discount Healthcare (see mailing address below).



Order by Mail

1. Call our Toll-Free customer service line at 1-877-223-1886 to speak with one of our friendly customer service representatives to obtain pricing of your medications and payment methods available,
2. Complete the order form ([available here](#))
3. Mail the completed forms and original prescription for the medications being ordered to our mailing address below:

Our toll free phone number is: **1-877-223-1886**
Our toll free fax number is: **1-877-536-2004**

Our mailing address is: **CDHC**
213 LaBree Ave. N
Suite 102
Thief River Falls, MN
56701

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A. Authorization & Release Form

B. Patient Allergy/Interaction Form

PaylessMeds Pharmacy / Canada Discount HealthCare

The undersigned, (Hereinafter the "Client") confirms that:

1. The Client is of the age of majority in the jurisdiction in which the Client ordinarily resides ("Place of Residence").
 2. The Client is not restricted from making his or her own medical decisions under the laws of the Place of Residence of the Client.
 3. The Client confirms to Canada Discount HealthCare and Canada RX Online Inc. (hereinafter "The Providers") that the pharmaceutical(s) ordered by the Client ("the Ordered Product") were prescribed by a duly qualified medical practitioner in the Place of Residence of the Client.
 4. The Client has not violated any laws in the place of Residence of the Client in obtaining the prescription for the Ordered Product.
 5. The Client confirms that the Ordered Product will not be used in any way whatsoever, except as prescribed by the duly qualified medical practitioner who issued the Prescription to the Client ("The Client's Doctor").
 6. The Client confirms that no person other than the Client will use the Ordered Product.
 7. The Client releases and discharges The Providers, and all of their officers and directors, agents, and employees from any and all liability, claims or causes of action with respect of the use or application of the Ordered Product by the Client, including, but not limited to undesired side effects.
 8. The Client confirms the release in the preceding paragraph also benefits and protects any Canadian Physician retained by the Providers to lawfully issue the prescription in Canada as directed by the Client's Doctor.
 9. The Client agrees that no child protective packaging will be used by the Providers and the Client releases and discharges the Providers and all of their officers and directors, agents and employees from any and all causes of action and with respect errors or omissions by the company or agency responsible for transporting the Ordered Product to the Client.
 10. The Client grants Limited Power of Attorney to the Providers, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the ordered Product to the Client, in the same manner as the Client could, if the Client had personally attended at the Providers place of business in Winnipeg, Manitoba, Canada.
 11. The Client attorns to the jurisdiction of Manitoba and agrees that any dispute that arises between the Client and the Providers shall be governed by the laws of the Province of Manitoba and the Federal Government of Canada, as applicable.
 12. The Client further agrees that if any dispute shall arise between the Parties pursuant to this Agreement as to the rights or liabilities of the parties to this Agreement, then every such dispute shall be referred to a single arbitrator if the parties can agree upon one. Otherwise, upon motion of either party to any Judge of the Court of Queen's Bench for Manitoba, such judge shall be entitled to name a single arbitrator, whose appointment shall be final and binding upon the parties. In all respects, subject to the terms of this agreement. The Arbitration Act of Manitoba and amendments thereto shall govern such proceedings and the arbitrator shall be entitled to fix and apportion liability for the costs of the arbitration. The award or determination which shall be made by the said arbitrator shall be absolutely final and binding upon the parties.
 13. The Client acknowledges that the Ordered Product may not be returned for a refund or an exchange.
 14. The Client release and discharge Canada Discount Healthcare and its directors, officers, agents, and employees from any and all liability, claims, or actions arising out of the use or application of my medication.
- BY SIGNING THIS DOCUMENT THE CLIENT CONFIRMS THAT HE/SHE HAS READ AND UNDERSTOOD THESE TERMS AND THAT THEY ARE TRUE AND CORRECT AND THE CLIENT AGREES THAT THE TERMS HEREIN ARE BINDING ON THE CLIENT AND THE HEIRS ASSIGNS, SUCCESSOR AND PERSONAL REPRESENTATIVES OF THE CLIENT.

Signature X _____

Print Name _____ Date: _____

Patient Allergy/Interaction Form needs to be submitted only on the first order.

Patient Name: _____

Date of Birth: _____

SSN# _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:(day) _____ (eve) _____

Email Address: _____

Insurance #: _____

Known Drug Allergies:

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

Current Medications Or Ones Used In Past 12 Months:

- | | |
|----------|-----------|
| 1) _____ | 7) _____ |
| 2) _____ | 8) _____ |
| 3) _____ | 9) _____ |
| 4) _____ | 10) _____ |
| 5) _____ | 11) _____ |
| 6) _____ | 12) _____ |

Patient Counseling:

Would you accept a generic brand drug? Yes No

Should pharmacy ship RX in child-proof containers? Yes No

Is this new medication? Yes No

If this is a new medication, would you like to speak to a pharmacist?
Yes No (I waive pharmacy counseling. Please just ship my order.)

If yes, how would you like to be contacted?

Telephone: _____

Fax: _____

Email: _____

Signature X _____ Date: _____

Office Use Only:

Counseling Completed _____ Date: _____



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Canadian Medication Order and Re-Order Form

Important: Contact us at 1-877-223-1886 for payment options

Patient Name: _____ Date of Birth: _____
Address: _____ Email Address: _____
City: _____ State: _____ Zip Code: _____
Telephone (Day): _____ Telephone (Evening) _____

Payment Method: Personal Check (TCP International OR Canada Rx Online Inc.)

Credit Card Credit Card# _____ Expire Date: _____

Name (as it appears on Card) _____ Total Amount: _____ CVN: _____

Signature: _____ Date: _____

***** CALL TO CONFIRM PAYMENT OPTIONS BASED ON YOUR ORDER *****

Requested Medication	Dosage	Quantity	Price (US\$)
			Sub Total (US\$)
			Shipping
			Total Amt Due

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