Patient Order Form

LeFave Pharmacy

Phone: 877.588.7868 **Fax:** 989.354.3286 **Internet:** www.lefavepharmacy.com

Mailing Address: 1202 W. Chisholm St. Alpena, MI 49707

Personal Information

Full Name (please print clearly) ◯ Male ◯ Female

Street Address

City State Country Zip

( ) ( )

Phone (Home) Phone (Other)

Email Birthdate (MM/DD/YY) / /

Best time to be contacted

Please check if you are placing this order for a pet.

◯ Cat ◯ Dog ◯ Other (Please specify)_____

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, called/e-script/faxed in from your Doctor). **PRICING IN $US DOLLARS**

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
FREE SHIPPING FOR 6 MONTH SUPPLY OR MORE, $8 FOR ALL OTHERS				
◯ Check box if you do NOT want childproof caps.			**TOTAL:**	

Payment Options

Credit Card

◯ Visa ◯ MasterCard ◯ Discover ◯ American Express

Cardholder's Name

Cardholder's Address

City State Country Zip

Credit Card Number

Credit Card Expiry (MM/YY) / CVV Code

OR

◯ I will make a payment by enclosed check

LeFave Pharmacy
1202 W. Chisholm St.
Alpena, Michigan 49707

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 Country Zip

( ) ( )

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

Patient Authorization (Please Check One)

The following terms and conditions govern the sales as between LeFave Pharmacy (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 18, 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 & dispensed by a Pharmacy operating within the Michigan 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 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 FDA 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.

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 18, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."

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

Prescription Submission

LeFave Pharmacy

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Please use this form to submit your prescription(s), and send it back to us to complete your order.

Full Name

( ) Phone Number

Order Number (if available)

☐ Option 1: Doctor Will Fax My Prescription*

Physician's Name

Clinic Name

Street Address

City State Country Zip

( ) Phone Number Ext. ( ) Fax Number

☐ Option 2: Transfer From Another Pharmacy*

Pharmacy Name

Street Address

City State Country Zip

( ) Phone Number Ext. ( ) Fax Number

Please list the medications that will be faxed from your doctor, or to be transferred from another pharmacy.

Drug Name	Strength	Directions	Rx Number

* A fax from your doctor, and transferring from another pharmacy is only available to residents of the United States

☐ Options: Mail Your Prescription

Please mail your prescription and this form to:

LeFave Pharmacy
1202 W. Chisholm St.
Alpena, Michigan 49707