207 E Main St, Remington, VA 22734 ● Toll Free: 800.675.8041 ● Ph: 540.439.3247 ● Fax: 540.439.9822 ● Email: info@remingtondrug.com

Payment & Patient Authorization Form

PAYMENT OPTIONS ☐ One Time ☐ Recurring

Credit Card ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

_____

Cardholder's Name

_____

Cardholder's Address City State Zip

_____

Credit Card Number Credit Card Expiry Date (MM/YY) CVV Code

PATIENT AUTHORIZATION (PLEASE CHECK ONE)

The following terms and conditions govern the sales as between Remington Drug Co (the "Pharmacy") and the individual (the "Patient") regarding the products and services (the "Services") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that,

☐ "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 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 Virginia 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 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, HERS AND PERSONAL REPRESENTATIVES."

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 to the Pharmacy on the Patient's behalf."

→ _____ _____

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