

PATIENT ORDER FORM



RIVERSIDE VILLAGE PHARMACY

Phone: (615) 650 - 4444 Fax: (615) 650 - 6828 Internet: www.RVPDrugs.com

Mailing Address: 1406A McGavock Pike Nashville, TN 37216

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) CVW Code



OR

I will make a payment by enclosed check

Riverside Village Pharmacy
1406A McGavock Pike
Nashville, TN 37216

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 between Riverside Village 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:

- 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 physical within the last 12 months, and do not require a physical examination.
- I understand that all Products shall be sold & dispensed by a Pharmacy operating within the Tennessee Board of Pharmacy jurisdiction and in a manner consistent with the laws of the United States of America.
- I authorize and appoint the Pharmacy, as my attorney and agent, to take all the steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purpose of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packing my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my 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.
- 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 FORM



RIVERSIDE VILLAGE PHARMACY

Phone: (615) 650 - 4444 Fax: (615) 650 - 6828 Internet: www.RVPDrugs.com

Mailing Address: 1406A McGavock Pike Nashville, TN 37216

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:

Riverside Village Pharmacy
1406A McGavock Pike
Nashville, TN 37216