Scope North Rx

Please complete all sections clearly in BLOCK LETTERS. Fields marked * are required.

1. Customer Information

First Name *

Last Name *

Date of Birth *

MM/DD/YYYY

Phone Number *

e.g. (000) 000-0000

Email Address

e.g. name@email.com

Shipping / Mailing Address *

Street Address *

Street Address Line 2 (Apt, Suite, etc.)

City *

State *

Zip Code *

Country *

2. Doctor Information

Prescribing Doctor's First Name *

Prescribing Doctor's Last Name *

Prescribing Doctor's Phone #

Prescribing Doctor's Fax #

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Please complete all sections clearly in BLOCK LETTERS. Fields marked * are required.

3. CURRENT MEDICATIONS & ALLERGIES

List of Meds *

Allergies (Enter "NO" if not applicable) *

4. PRESCRIPTION

Prescription Details or Additional Instructions

5. PAYMENT PREFERENCE

Payment Method

☐ Credit Card ☐ E-check ☐ Wire Transfer

6. SHIPPING METHOD

☐ Express Service (signature required) ☐ Expedited Service (signature not required)

TERMS AND CONDITIONS

- A prescription will be required prior to fulfilling and dispensing of any prescription order.
- Scope North Rx will process orders once all necessary information is provided https://scopenorthrx.com/terms-of-service/
- Prescription orders may require verification with the prescribing doctor.
- Maximum of 3-month supply for personal usage can be ordered.
- All Cold Chain shipments will be shipped via Express Service (signature required).
- Narcotics and controlled products are prohibited.
- Payments are processed prior to pharmacy processing and delivery of shipments.
- All shipped orders are insured and subject to review in the event of missing or damaged shipments.

Patient Signature	**Date**

Please return this completed form by email or fax and one of our representatives will get back to you as soon as possible.

Email: *info@scopenorthrx.com*
Fax: 1 (888) 404-4027
Phone: 1 (888) 404-3060
Hours of Operation: 9am-5pm EST Monday-Friday