PAXMAN CANADA ENROLMENT FORM

paxmanscalpcooling.com

PLEASE TAKE THIS FORM TO YOUR PAXMAN CONSULTANT.

Paxman Coolers Limited
International House, Penistone Rd,
Fenay Bridge, Huddersfield, HD8 0LE, UK.

Harry Goodman
Cell: 647-632-9625
harry@paxmanscalpcooling.com

STEP 1 PATIENT INFORMATION (*Required Fields)

First Name*: | MI: | Last Name*: | DOB*: MM / DD / YY

Address*:

City*: | Province:

Postal Code: | Home Phone Number*:

Gender: M F | Cell Phone Number*:

Preferred Number to Call: Home Phone Cell Phone

Email Address: | Tick box to opt-out of receiving educational and marketing material:

STEP 2 PRESCRIBER/PHYSICIAN INFORMATION (*Required Fields)

Prescriber/Physician First Name*: | Prescriber/Physician Information Last Name*:

Facility/Practice Name*:

Practice Address*:

City*: | Province*: | Postal Code*:

CPSO License #:

Other Contact First and Last Name:

Other Contact Email Address: | Tick box to opt-out of receiving educational and marketing material:

Physician Contact Phone #*:

Physician Email Address: | Tick box to opt-out of receiving educational and marketing material:

STEP 3 TREATMENT AND PRESCRIPTION INFORMATION AND PRESCRIBER/PHYSICIAN AUTHORIZATION

Diagnosis:

Chemotherapy type/dose/Frequency:

Therapy Start Date:

Directions: **Use as directed** | Quantity: **One**

Prescribed Treatment Days*: 1 2 3 4 5 6 7 8 9 10

Other No. of Treatment Days:

PRESCRIBER/PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING

I certify that (i) the information contained on this form is accurate to the best of my knowledge and (ii). I am the prescribing healthcare provider of Paxman Scalp Cooling Cap to the previously identified patient and that I provided the patient with the description of the Paxman program. For purposes of transmitting this prescription, I authorize Paxman US, Inc. and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy.

Dispense as Written: *If this form does not meet your Provincial's requirements for a valid prescription, please attach a valid prescription (or eprescribe).*

Prescriber Signature*: | Date*: MM / DD / YY

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Patient Full Name*	Patient DOB*	Prescriber/Physician Name*	Prov. Lic. #*

PATIENT CONSENT IS ALSO MANDATORY FOR PROCESSING (*Required Fields)

Change to: I authorize my health care providers, pharmacies, and health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal Information") to Paxman, its affiliates, business partners, service providers, third-party contractors, and agents so that the Paxman can provide me with the Patient Support Services available for the Paxman Scalp Cooling Cap prescribed by my HCP on this Enrolment Form to (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with this product including to locate alternative funding sources, (ii) coordinate my receipt of, and payment for this product, (iii) facilitate my access to this product, (iv) provide me with information about this product and management programs and educational materials, (v) manage the Patient Support Services, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Patient Support Services. I give permission to the Paxman to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I can refuse to sign this Authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits or Paxman products; however, if I do not sign this Authorization, I will not be able to receive Patient Support Services. I also may revoke this authorization at any time in the future by writing to Paxman Coolers Limited, International House, Fenay Bridge, Huddersfield, HD8 0LE UK. If I revoke this authorization, I may no longer be eligible to participate in the Patient Support Services. If I revoke this authorization, the Paxman will stop using or sharing my information (except as necessary to end my participation in the Services) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five years after the date of my signature, unless I revoke it earlier. I also understand that the Patient Support Services may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

Patient Signature*:	Date*: MM / DD / YY

I appoint the person named below to act as a representative for me and/or my minor child. I authorize the representative to receive, discuss, and disclose my personal information. This authorization does not give the representative authority over treatment or direct-care decisions.

Name:	Contact Number(s):
Relationship to Patient:	

(*Required Fields)