**Health Intake Form**

*Please take a few minutes to complete this health intake form. Accurate information will help us in evaluating your medical status and taking care of your medical needs. Thank you!*

Print Name Date of Birth

Age Sex Height Weight Phone Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live with anyone? (Children in the home, caregiver, assisted living) Yes or No If Yes, Who?

Have you designated and registered a caregiver with the compassionate use registry? If yes, please provide the name and registry ID number of your caregiver. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. How did you hear about us?  Physician Patient Advertisement  Web search
  2. What is the name of your primary care doctor (if any)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  3. Please choose the condition(s) you believe qualifies you for medical marijuana:

Cancer Epilepsy HIV/AIDS Post-traumatic stress disorder ALS (Lou Gehrig’s disease)

Crohns Disease Parkinson’s disease Multiple Sclerosis Other Seizure disorder Chronic muscle spasm

Other terminal condition (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other comparable condition (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. How did this begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. When did this first start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  3. On a scale of 0-10 (0=no impact at all; 10= totally interferes with your life), what number do you rate your health condition?
  4. How is your appetite?  Normal  Decreased  Increased
  5. Do you require any assistive devices (walker, wheelchair, shower chair, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  6. Have you ever had a history of drug or alcohol abuse?  Yes  No
  7. Have you ever been treated for a psychiatric disorder?  Yes  No
  8. Psychiatric diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  9. Name of Mental Health Facility or Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  10. Have you ever thought of harming yourself or others?  Yes No
  11. Name of any prior or current substance abuse Treatment Programs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or  none/not applicable

## MEDICAL HISTORY

1. List all drug and non-drug substances that you are allergic to:
2. Check all the following medical problems Yourself, Mother, Father or Siblings are currently or have ever been treated for.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Y | | M | | F | | S | |  | | Y | | M | | F | | S | |  | | Y | | M | | F | | S | | Seizures |
|  | |  | |  | |  | | Asthma/COPD | |  | |  | |  | |  | | Muscle Disorders | |  | |  | |  | |  | | Stroke |
|  | |  | |  | |  | | Glaucoma | |  | |  | |  | |  | | GERD/Reflux | |  | |  | |  | |  | | Alzheimer Disease |
|  | |  | |  | |  | | Ear/Nasal Problem | |  | |  | |  | |  | | Stomach Ulcer | |  | |  | |  | |  | | Parkinson Disease |
|  | |  | |  | |  | | Thyroid Disease | |  | |  | |  | |  | | Prostate Problems | |  | |  | |  | |  | | Vascular disease |
| Y | M | | F | | S | |  | | Y | | M | | F | | S | |  | | Y | | M | | F | | S | |  | |
|  |  | |  | |  | | Arrhythmias | |  | |  | |  | |  | | Bladder Problems | |  | |  | |  | |  | | Headache Disorders | |
|  |  | |  | |  | | Heart Disease | |  | |  | |  | |  | | Liver Disease | |  | |  | |  | |  | | High Blood Pressure | |
|  |  | |  | |  | | Mitral Valve Prolapse | |  | |  | |  | |  | | HIV/AIDS | |  | |  | |  | |  | | Bowel Problems | |
|  |  | |  | |  | | Aneurysm | |  | |  | |  | |  | | Kidney Disease | |  | |  | |  | |  | | Diabetes | |
|  |  | |  | |  | | Congestive Heart Fail. | |  | |  | |  | |  | | Psychiatric | |  | |  | |  | |  | | Heart Attack/Angina | |

Please explain any responses above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Mother is:  Living and well  Living, health problems  Living, unknown health history  Deceased(cause)\_\_\_\_\_\_\_\_\_\_\_\_
2. Father is:  Living and well  Living, health problems  Living, unknown health history  Deceased(cause)\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. List all major surgeries: a. b.

c. d. e. \_\_\_\_\_\_\_\_ f. \_

1. Circle all the symptoms you are currently experiencing

|  |  |  |  |
| --- | --- | --- | --- |
| unexplained [weight loss](https://en.wikipedia.org/wiki/Weight_loss) | [fatigue](https://en.wikipedia.org/wiki/Fatigue_(medical))/[malaise](https://en.wikipedia.org/wiki/Malaise)/[lethargy](https://en.wikipedia.org/wiki/Lethargy) | [visual changes](https://en.wikipedia.org/w/index.php?title=Visual_changes&amp;action=edit&amp;redlink=1) | [headache](https://en.wikipedia.org/wiki/Headache) |
| Altered sleep patterns | unexplained falls | Change in appetite | [chest pain](https://en.wikipedia.org/wiki/Chest_pain) |
| [palpitations](https://en.wikipedia.org/wiki/Palpitation) | Fainting/ loss of consciousness | cough | [shortness of breath](https://en.wikipedia.org/wiki/Shortness_of_breath) |
| Nausea/vomiting | Diarrhea/ Constipation | Abdominal pain | Urinary frequency |
| Urinary retention/ hesitancy | Joint stiffness/swelling | Muscle spasms | Neck/Back pain |
| Rashes | Wounds | difficulty [concentrating](https://en.wikipedia.org/wiki/Attention_span) | [lack of energy](https://en.wikipedia.org/wiki/Fatigue_(medical)) |
| Anxiety | Loss of balance | Paranoia | depression |
| Change in sight/smell/sound/taste | hallucinations | Cold/heat intolerance | tremors |

1. Are you working?  Full time  Part time  Unemployed  Workers’ Comp  Disabled  Retired
2. What type of work did you or do you perform?

|  |  |  |  |
| --- | --- | --- | --- |
| 9. | Do you smoke cigarettes currently?  Yes  No If yes, how many cigarettes do you smoke per day? Or former smoker?  Yes No | | |
| 10. | Do you drink alcohol?  Yes🞏No If yes, how often and much? | | |
| 11. Last menstrual period? \_\_\_\_\_\_\_\_  12. Could you be pregnant? Yes    13. Are you breast feeding? 🞏Yes🞏No | | 🞏No | If yes, how many weeks? \_\_\_\_\_\_\_\_ |

## Please list all medications you are currently taking (include aspirin, ibuprofen, vitamin E, herbal remedies)

|  |  |  |
| --- | --- | --- |
| **Name of Drug** | **Dose (mg and times per day)** | **Reason** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |
| 9. |  |  |
| 10. |  |  |

Please List all previous treatments (including all medications) you have tried for the disease process you are requesting treatment for:

|  |  |  |
| --- | --- | --- |
| **Date and type of treatment** | **Treating physician** | **Outcome/results** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |
| 9. |  |  |
| 10. |  |  |

Patient Signature Date

Print Name Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (Please Print)

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

City State Zip

Age Sex SS#

Preferred Language Occupation

Marital Status:  Married  Single  Divorced  Other

Home Phone # Cell Phone #

Work Phone#

Emergency Contact Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# Alternate#

**I consent to treatment necessary for the care of the patient indicated on this form.**

Patient/Guardian/Guarantor Signature Date

## 

**Appointment Details**

DATE: TIME:

DOCTOR: LOCATION:

## WE DO NOT ACCEPT CHECKS AS FORM OR PAYMENT FOR ANY SERVICE PROVIDED. WE DO ACCEPT CASH, CREDIT, OR DEBIT``

## WITHOUT YOUR VALID FLORIDA STATE ISSUED DRIVER’S LICENSE OR IDENTIFICATION CARD AND FLORIDA COMPASSIONATE USE REGISTRY CARD, YOU WILL NOT BE ELIGIBLE FOR EVALUATION.

**IF YOU ARE UNABLE TO COMPLETE THIS PAPERWORK YOU MUST BRING SOMEONE WITH YOU TO YOUR APPOINTMENT THAT CAN ASSIST YOU WITH THIS PACKET.**

**NO SHOW POLICY** – To assure that all our patients have access to care when needed by maximizing the utilization of available appointments, you (the patient) are required to cancel your scheduled appointment with appropriate prior notice (24 hours.) Failure to cancel your appointment without 24-hour notice is considered a “No Show.” Any “No Show” event will incur a $50.00 penalty fee that will be charged to your account. You will be required to pay this fee prior to being seen for another appointment. Please note there is no “grace period” for your appointment time- late arrivals are considered a “No Show” and will need to reschedule.

PRINT NAME Date of Birth

SIGNATURE Today’s Date

## IF YOU HAVE AN HMO OR AN INSURANCE PLAN THAT PROVIDES COVERAGE FOR MEDICAL MARIJUANA: It is up to you as the patient to provide any documentation they may require. Due to federal law regarding medical marijuana, we (Ameri-Cann Wellness Clinic) do no file claims with any insurance company, or accept payment from any insurance company. All payments are expected at the time of visit. Patients will be rescheduled if full payment is not rendered (this would be considered a “no show” event)

## VERY IMPORTANT

## WHEN YOU RECEIVE THIS PACKET, IT IS VERY IMPORTANT THAT YOU CALL OUR OFFICE AND LET US KNOW YOU HAVE YOUR PAPERWORK. IF YOUR NEW PT PACKET IS NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT, YOUR APPOINTMENT WILL BE RESCHEDULED.

## AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: Date of Birth:

Patient Address: Pt selected 6-digit PIN #

(Do not use DOB)

By signing below, you hereby authorize us to use or disclose information about yourself (or person for whom you have the authority to sign) that may be protected under federal law, for the sole purpose and timeframe described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and request copies of that health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of use and disclosure: MRI, CT, XRAY, and Lab reports; last H&P, evaluation, and office notes for the purposes of evaluation and treatment; other:

The name or other specific identification of the person(s), or class of persons, *authorized to receive the requested use or disclosure:*

**Please *initial* boxes:**

(Initial box) I hereby authorize AMERI-CANN WELLNESS CLINIC to electronically disclose my health information to

Florida Compassionate Use Registry. ***Failure to authorize will preclude you from receiving a medical marijuana recommendation***

(Initial box) I hereby authorize AMERI-CANN WELLNESS CLINIC to verbally disclose my health information to any person than provides my self-selected 6-digit PIN number as well as the following:

*Authorized Individual(s) /Relationship to Patient*

(Initial box) I hereby authorize AMERI-CANN WELLNESS CLINIC to verbally disclose my health information on my home answering machine/voicemail on phone/cell phone.

This information about you may be protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already acted in reliance on your authorization. By signing below, you recognize that the health information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of this disclosure and may no longer be protected under federal law. You may refuse to sign the authorization.

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the AMERI-CANN WELLNESS CLINIC: “Notice of Privacy Practices” which set forth AMERI-CANN WELLNESS CLINIC’S privacy practices and my rights regarding privacy of my protected health information.

Patient/Personal Representative Signature

Print Name Date

## CONSENT FOR TREATMENT WITH MEDICAL MARIJUANA

**Please *initial* all boxes:**

I understand I have a QUALIFYING CHRONIC condition that may benefit from the RECOMMENDATION FOR USE OF MEDICAL MARIJUANA.

Any side effects such as dry mouth, dizziness, increased appetite, memory impairment, and lack of motivation, anxiety, depression, paranoia, sedation, and lung problems and the use of substances to counteract these side effects have been explained to me. The issues of tolerance, drug dependence and addiction have been fully explained to my satisfaction.

I understand that there are alternatives to MEDICAL MARIJUANA therapy which include multidisciplinary therapies such as physical therapy, and/or exercise, TENS, cognitive/behavioral therapy, acupuncture, and prescription medications

### The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my daily functioning.

I understand that daily MEDICAL MARIJUANA use may increase certain risks, which include, but are not limited to:

* Addiction Increased appetite, unwanted weight gain
* Impaired memory or judgment Allergic reactions, overdose and fatal complication
* Breathing problems Dizziness
* Sleepiness and confusion Kidney/Liver damage
* Cardiac damage Possible Sexual dysfunction
* Complication to pregnancy or breastfeeding Impaired ability to operate machines or drive motor vehicles

I also understand the following guideline:

As a patient, I understand I will not receive more than a 45-day supply per MD discretion and Florida regulations. Insurance plans and pharmacy programs do not cover medical marijuana. The cost of the product, ***which must be purchased from a legally licensed medical marijuana dispensary,*** is the sole responsibility of the patient.

I also understand that if I do not follow the substance abuse guidelines and any additional testing requirements as necessary (separate contract), my treatment may be terminated.

I have discussed the benefits, risks, and alternatives to MEDICAL MARIJUANA treatment with my provider. I have had an opportunity to ask questions and have received answers to those questions to my satisfaction.

## DIVERSION POLICY

WHAT IS DIVERSION? — “The act or an instance of diverting from a course, activity or use.”

Diversion is against the law and AMERI-CANN WELLNESS CLINIC takes this very seriously. If diversion occurs, you will be immediately discharged from our practice without a refund.

Here are some examples of what diversion is when discussing medical marijuana.

1Having a friend, family member, neighbor, or co-worker give or sell you marijuana because you missed your appointment with your doctor.

1. Attempting to get a medical marijuana certification from more than one doctor.
2. Giving away or selling your medical marijuana.
3. Having a positive urine test result for medical marijuana when your registry does not show medical marijuana dispensed for over 75 days.
4. Having a negative urine test result for medical marijuana showing filled by registry within the last 45 days.
5. A positive urine drug screen for any **unreported** drug (even those legally obtained)
6. A positive urine test result for any illicit drug is a mandatory discharge.

**I READ THE ABOVE AND UNDERSTAND IT TO THE BEST OF MY KNOWLEDGE**

Patient Signature Date

Print Patient Name Date of Birth

Provider Signature Date

**Health Care Operations** - We may use and disclose health information about you for health care operations, including, for example: quality assurance, peer review, and risk management activities; administrative activities, including AMERI-CANN WELLNESS CLINIC financial and business planning and development; and customer service activities, including investigation of complaints. These uses and disclosures are necessary to operate AMERI-CANN WELLNESS CLINIC and make sure all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of the AMERI-CANN WELLNESS CLINIC clinicians who care for you.

**Business Associates** - There are some services provided in our organization through contracts with business associates. Examples of business associates include billing companies, management consultants, quality assurance reviewers, etc. We may disclose your health information to our business associates so that they can perform the job we’ve asked them to do. To protect your health information, we require our business associates to sign a contract that states they will appropriately safeguard your information.

**Appointment Reminders** - We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care from an AMERI-CANN WELLNESS CLINIC clinician. We may call you and leave information on your answering machine regarding food and liquid restrictions prior to a surgery and procedures, unless you tell us not to.

**Individuals Involved in your care or payment for your care** - We may disclose health information about you to a friend or family member who is involved in your medical care, unless you tell us in advance not to do so. We may leave preoperative or postoperative instructions for you on an answering machine or voice mail at the phone number you have provided to AMERI-CANN WELLNESS CLINIC or the facility where you will be receiving care, unless you tell us not to do so.

## WITH YOUR SPECIFIC WRITTEN “AUTHORIZATION”

If there are reasons we need to use your information that has not been described in the sentences above, we will obtain your written permission (called “authorization”). If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Some typical disclosures that require your written authorization, or the written authorization of your representative are for disclosure of Drug and Alcohol Abuse Treatment, HIV and AIDS Test Results, and Mental Health Treatment.

## SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR INFORMATION CONSENT OR AUTHORIZATION

We will disclose health information about you without your permission when required to do so by federal, state or local law. The following disclosures are permitted by law without any oral or written permission from you, although this list is not intended to be all-inclusive:

**Organ and Tissue Donation** - If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans** - If you are a member of the armed forces, we may release health information about you as required by military command authorities.

**Worker’s Compensation** - We may release health information about you for worker’s compensation or similar programs if you have a work related injury. These programs provide benefits for work related injuries.

Acknowledgement of receipt of AMERI-CANN WELLNESS CLINIC Patient Privacy Notice (HITECH compliant)

Print Patient Name: Date of Birth: Patient/Guardian/Parent Signature: Date: Relationship:

Ameri-Cann Wellness Clinic

2177 SE Ocean Blvd.

Stuart, FL 34994

772-281-1520

HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT

TO 45 CFR 164.508

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF HEALTHCARE PROVIDER/PHYSICIAN/FACILITY/MEDICARE CONTRACTOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number Fax Number

RE: PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE AND REQUEST THE DISCLOSURE OF ALL PROTECTED INFORMATION FOR THE PURPOSE OF REVIEW AND EVALUATION. I EXPRESSLY REQUEST THAT THE DESIGNATED RECORD CUSTODIAN OF ALL COVERED ENTITIES UNDER HIPAA IDENTIFIED ABOVE DISCLOSE FULL AND COMPLETE PROTECTED MEDICAL INFORMATION INCLUDING THE FOLLOWING:

\_\_\_\_\_\_\_ LAST 3 OFFICE VISITS –OR—FROM \_\_\_\_\_\_\_\_ TO \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ ALL XRAY, MRI AND CT SCAN REPORTS

\_\_\_\_\_\_\_ LAST 3 MONTHS OF LAB WORK

\_\_\_\_\_\_\_ DISCHARGE LETTER

I understand the following: See CFR 164.508(c) (2) (i-iii)

1. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
2. The information released in response to this authorization may be re-disclosed to other parties.
3. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.
4. I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance use disorders, sexual abuse and/or other related conditions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Relationship of Legally Authorized Representative to Patient

See 45CFR 164.508 (1) (iv)

Please Fax Records to: 772-210-5313 Attn: Medical Records Department

INFORMED CONSENT FOR LOW-THC CANNABIS AND MEDICAL CANNABIS

The purpose of this agreement is to ensure that the patient has given accurate information upon which the doctor can rely in implementing a pain management program. It is also to prevent misunderstandings about the Low-THC Cannabis or Medical Cannabis you will be taking. This is to help both you and your physician comply with the law regarding Low-THC Cannabis or Medical Cannabis.

**PLEASE CAREFULLY READ AND INITIAL THE FOLLOWING:**

I am being evaluated for a physician’s recommendation for medicinal use of Low-THC Cannabis or Medical Cannabis. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use Low-THC Cannabis or Medical Cannabis only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of Low-THC Cannabis or Medical Cannabis. I have been informed of and understand the following: The State of Florida requires physicians obtain voluntary, written informed consent from the patient, or the patient’s legal representative, to treatment with Low-THC Cannabis or Medical Cannabis. I have been informed of and understand the following: [please initial each item]

1.\_\_\_\_\_\_\_ I understand the current state of knowledge is limited in the medical community on the effectiveness of treatment of a patient's condition with Low-THC Cannabis or Medical Cannabis.

2.\_\_\_\_\_\_\_ I understand that the undersigned physician is a qualified physician who is registered with the Office of Compassionate Use and may order medical cannabis for my medical use if he feels I qualify as a patient who could benefit from this medical decision. My physician is not implying or suggesting that medical cannabis should be a substitute for any other treatment prescribed by another physician.

3.\_\_\_\_\_\_ I understand that I may not seek medical cannabis from any other physician while being a registered patient with Ameri-Cann Wellness Clinic.

4.\_\_\_\_\_\_The federal government has classified Marijuana, including Low-THC Cannabis and Medical Cannabis, as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of Low-THC Cannabis or Medical Cannabis even in states, such as Florida, which have modified their state laws to treat Low-THC Cannabis or Medical Cannabis as a medicine.

5.\_\_\_\_\_\_ Low-THC Cannabis and Medical Cannabis have not been approved by the Food and Drug Administration for marketing as a drug. Therefore the “manufacture” of Low-THC Cannabis or Medical Cannabis for medical use is not subject to any standards, quality control, or other oversight. Low-THC Cannabis or Medical Cannabis may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

6.\_\_\_\_\_\_ the use of Low-THC Cannabis or Medical Cannabis can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using Low-THC Cannabis or Medical Cannabis, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of Medical Cannabis, I can be arrested for “driving under the influence.”

7.\_\_\_\_\_\_ Potential side effects from the use of Low-THC Cannabis and Medical Cannabis include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body’s immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Medical Cannabis may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of Medical Cannabis may cause excessive talking or eating, altered perception of time and space and impaired judgment. Many medical authorities claim that use of cannabis, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, a tendency to drug abuse, and schizophrenia. Ameri-Cann Wellness Clinic Physicians recommend cannabis use only for the relief of serious symptoms, and not for habitual use.

8.\_\_\_\_\_\_\_ I understand that using Low-THC Cannabis or Medical Cannabis while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and Low-THC Cannabis or Medical Cannabis.

9.\_\_\_\_\_\_\_ I agree to contact Ameri-Cann Wellness Clinic if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Ameri-Cann Wellness Clinic if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

10.\_\_\_\_\_\_ Smoking Cannabis may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking Cannabis may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. Smoking Cannabis is not a covered medical use and is currently prohibited in the state of Florida.

11.\_\_\_\_\_\_ The risks, benefits and drug interactions of Low-THC Cannabis or Medical Cannabis are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using Low-THC Cannabis or Medical Cannabis and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

12.\_\_\_\_\_\_\_ I understand there are other medical acceptable alternatives and understand the potential risks and side effects of utilizing Low-THC Cannabis or Medical Cannabis. I received an explanation of the currently approved products and treatments for my condition.

13**.\_\_\_\_\_\_ I concur with my physician, in believing that all currently approved products and treatments are unlikely to prolong or improve life; and low-THC cannabis or Medical cannabis benefits outweigh the risk in my situation.**

14.\_\_\_\_\_\_ Individuals may develop a tolerance to, and/or dependence on, Cannabis. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on Cannabis, I should contact Ameri-Cann Wellness Clinic.

15.\_\_\_\_\_\_\_Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

16.\_\_\_\_\_\_\_ Symptoms of Cannabis overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Ameri-Cann Wellness Clinic immediately or go to the nearest emergency room.

17.\_\_\_\_\_\_\_ I understand that my eligibility for hospice care may be withdrawn if I begin treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if the treatment ends and I then meet hospice eligibility requirements.

18. \_\_\_\_\_\_\_I understand that my health plan or third-party administrator and physician are not obligated to pay for care or treatment consequent to the use of the investigational drug, biological product, or device unless required to do so by law or contract.

19.\_\_\_\_\_\_\_ I understand I am liable for all expenses consequent to the use of the investigational drug, biological product, or device and that liability extends to my estate, unless a contract between myself and the manufacturer of the investigational drug, biological product, or device states otherwise.

20.\_\_\_\_\_\_\_ I understand that Medical Cannabis is offered as treatment for specific medical conditions and/or symptoms as designated by the Florida Department of Health, Office of Compassionate Use- this may be subject to change based on state law.

21.\_\_\_\_\_\_\_ If Ameri-Cann Wellness Clinic subsequently learns that the information I have furnished is false or misleading, the recommendation for Low-THC Cannabis or Medical Cannabis may no longer be valid. I agree to promptly meet with Ameri-Cann Wellness Clinic and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

22.\_\_\_\_\_\_\_ I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Ameri-Cann Wellness Clinic has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding Low-THC Cannabis or Medical Cannabis. Ameri-Cann Wellness Clinic also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that Ameri-Cann Wellness Clinic informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

23.\_\_\_\_\_\_ Pregnancy and breast-feeding: Medical Cannabis is UNSAFE when taken during pregnancy. Cannabis passes through the placenta and can slow the growth of the fetus. Cannabis use during pregnancy is also associated with childhood leukemia. Using Cannabis, either by mouth or by inhalation is LIKELY UNSAFE during breast-feeding. The tetrahydrocannabinol (THC) in Medical Cannabis passes into breast milk. Medical Cannabis will be discontinued in the event of a pregnancy

24.\_\_\_\_\_\_\_When under the influence and/or in possession of cannabis in public, your state issued Marijuana registry card must be carried.

25.\_\_\_\_\_\_\_ To stay in compliance with the Florida department of health regulations, it is required that you return your recommending physician for a review of your medical condition and an update of your recommendation every six weeks. If you are overdue for your visit, your recommendation and all active orders will be suspended. An outdated recommendation may place the Doctor’s Medical License in jeopardy with the Medical Board, and the patient is at risk of being fined or arrested. If such an incident occurs, you may be discharged from the practice. Extensions can be given for personal emergency or special circumstances.

26.\_\_\_\_\_\_\_\_REMEMBER to bring your registry card and remaining supply of Low-THC Cannabis or Medical Cannabis with you to every visit If your registry card is lost or stolen, you must apply to the office of compassionate use for a replacement card. IF YOU DO NOT BRING YOUR REGISTRY CARD, YOUR APPOINTMENT WILL BE RESCHUDELED AND YOU MAY BE CHARGED A “NO-SHOW” FEE.

27.\_\_\_\_\_\_\_\_\_\_ Patients giving any dishonest or untruthful information will be discharged and report to local law enforcement and the office of compassionate use

28.\_\_\_\_\_\_\_\_\_ I understand that Ameri-Cann Wellness Clinic will register my case with the Florida Department of Health, Compassionate Use Registry and he will submit the treatment plan quarterly to the institution as designated by the legislature for the State of Florida for research purposes on the efficacy of medical cannabis to help treat patients.

29.\_\_\_\_\_\_\_\_ I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications, I will be discharged from my doctor’s care, and I may be criminally prosecuted. In this case, my doctor may taper off Medical Cannabis over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

30.\_\_\_\_\_\_\_\_ I will communicate fully with my doctor and staff about the character and intensity of my condition, the effects of my condition on my daily life, and how well Low-THC Cannabis or Medical Cannabis is helping to control my condition.

31. \_\_\_\_\_\_\_ I will NOT use any illegal controlled substance, including street marijuana, cocaine, etc., or any other medication prescribed to anyone other than myself.

32. \_\_\_\_\_\_\_ I will not share, sell or trade my Low-THC Cannabis or Medical Cannabis with anyone.

33. \_\_\_\_\_\_\_\_ I will notify Ameri-Cann Wellness Clinic of all medications I take- including any controlled or non-controlled prescription medication, opioid pain medicines, controlled stimulants, anti-depressants, mood-stabilizers or anti -anxiety medicines. In turn, I will notify my alternate prescribers of my use of Low-THC Cannabis or Medical Cannabis

34. \_\_\_\_\_\_\_\_ I will safeguard my Low-THC Cannabis or Medical Cannabis from loss or theft. I understand that lost or stolen products will not be replaced.

35.\_\_\_\_\_\_\_ I agree that recommendations for Low-THC Cannabis or Medical Cannabis will only be available during my regularly scheduled office visits. I understand that it is my responsibility to make and keep timely appointments. Recommendations will not be entered into the state registry outside of these visits.

36.\_\_\_\_\_\_\_ I authorize the doctor, facility and dispensary to cooperate fully with any city, county, state or federal law enforcement agencies, in the investigation of any possible misuse, sale or other diversion of Low-THC Cannabis or Medical Cannabis. I authorize my doctor to provide a copy of this agreement to my dispensary, primary care provider and referring physician. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

37.\_\_\_\_\_\_\_ I agree that I will submit to routine urine drug tests (and pregnancy test if applicable) as requested by my doctor to determine my compliance with my program of Low-THC Cannabis or Medical Cannabis. If I am unable to provide a urine specimen, I will be required to submit a blood or saliva sample to be tested (at my own expense).

38.\_\_\_\_\_\_\_ I agree that I will use my Low-THC Cannabis or Medical Cannabis at the prescribed rate and that use of my Low-THC Cannabis or Medical Cannabis at a greater rate will result in my being without Low-THC Cannabis or Medical Cannabis for a time.

39.\_\_\_\_\_\_\_ I have been fully informed of the psychological dependence (addiction) of Cannabis. I fully understand the behavioral effects of medications and agree to maintain appropriate behavior at all times with my clinicians and support staff. I will notify clinicians for assistance as needed for concerns regarding side effects. I know that some persons may develop a tolerance, which is the need to increase the dose of the cannabis to achieve the same effect of symptom control, and I do know that I may become physically dependent on cannabis.

40.\_\_\_\_\_\_\_\_ I understand that it is a criminal offense in the state of Florida to acquire or obtain or attempt to acquire or obtain possession of a controlled substance (including cannabis) by misrepresentation, fraud, forgery, deception or subterfuge. I understand that if I make any false statements in this agreement, I will be subject to criminal prosecution.

41.\_\_\_\_\_\_\_ I understand that I may be called into the office for random urine drug screening and/or Low-THC Cannabis or Medical Cannabis counts. I will be required to present myself to the office by the close of business on that day or I may be discharged from the practice.

42.\_\_\_\_\_\_\_ If my doctor recommends Low-THC Cannabis or Medical Cannabis I will use a licensed dispensary to fill the order.

43. Have you obtained a recommendation for a Low-THC Cannabis or Medical Cannabis from another qualified physician within the last year?

\_\_\_\_\_\_\_YES \_\_\_\_\_NO

**Patient abuse of medication is a serious problem. Please read this form carefully. You will be held to this agreement by your physician and by law enforcement agencies. I do hereby state that I have read this form completely, and that all the information is true and accurate. I understand that any false statements given in conjunction with this agreement will subject me to criminal prosecution. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me and will be reviewed at each visit.**

This agreement is signed and effective on this \_\_\_\_\_\_ (date) of\_\_\_\_\_\_\_\_\_\_\_\_ (month), 20\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME (PRINTED) AND DATE OF BIRTH PATIENT SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE WITNESS