FLORIDA

Patient intake and consent form

The content of this document is confidential. It intended to serve the Marijuana Specialist Doctor only. Distribution of this form is prohibited.

Please email the form to: dr.koffler@hmwcenter.com

IMPORTANT

If you don’t know the answer to some questions or a question is not relevant to youer case, please enter N/A

PATIENT IN-TAKE FORM

Date ______________________________

Patient ______________________________ Date of Birth ______________
Address ______________________________ Zip Code ______________
Home Tel# ______________ Cell ______________ Email ______________
Primary Care Physician ______________________ Phone# ______________
Pharmacy Name ______________________ Phone# ______________
Pharmacy Address ______________________________
In Case of Emergency ______________________ Relationship ______________
Address ______________________________
______________________________ Phone# ______________

PAST MEDICAL HISTORY

Hospitalizations — Date and Illness/Reason: ______________________________

Surgeries — Date and Type, including any body implants such as cardiac stents, heart valves, joint replacements, pacemakers: ______________________________

Ongoing Medical Problems, including asthma, COPD, diabetes, heart disease, heart murmur, hepatitis, HIV/AIDS, hypertension, kidney failure, venereal disease, alcohol or drug addictions, present or previous psychiatric care ______________________________

Allergies — Name Drug and Reaction, including any type of anesthetic: ______________________________

CLINICAL HISTORY and CONDITION

Indication(s) for Cannabis Treatment
Chief complaint for evaluation of cannabis treatment ______________________________

List of Symptoms — Type / Frequency / Severity
1. ______________________________
2. ______________________________
3. ______________________________

Prior Treatment(s), Duration and Outcome of Treatment ______________________________

RX Medication Name	Dosage	Regimen	Target Symptom

OTC/Vitamins/Supplements/Herbals/Homeopathies/Other Self-Medication

Med Name	Dosage	Regimen	Target Symptom

Are You Currently Taking Aspirin, Coumadin, Plavix, Persantine, or other blood thinners?
____

Preventative Care — List Ongoing Medical Treatments, Special Diets, Physical Therapies, etc.

____

____

____

If Female, Are You Currently Pregnant or Think That You May Be? YES / NO
Date of Last Menstrual Cycle _______________
Are You Planning on Getting Pregnant? YES / NO
Are you currently Breast-Feeding? YES / NO

FAMILY MEDICAL HISTORY

Hereditary Diseases, Significant Illnesses or Cause of Death of Grandparents/Parents/Children/ Siblings/Aunts/Uncles/Cousins, example allergy/bleeding disorders/cancer/heart disease/sickle cell anemia/psychiatric problems such as anxiety/bi-polar/depression, etc.

____

____

____

NUTRITIONAL HISTORY

Special Dietary Needs _______________

____

SOCIAL HISTORY and HABITS

Coffee _______________ cups/day Tea _______________ cups/day
Alcohol _______________ drinks/day/week Tobacco _______________ cigarettes/day
How Many Years Have You Been Smoking? If You Quit, When Did You Stop?

____

Do You Currently Use Marijuana? YES / NO
If YES, how often and by what method, does it help alleviate the symptoms of your qualifying condition?

____

____

____

Recreational Drug Use — Frequency/Type/Route, i.e. ingestion, injection, snorting

____

____

____

OFFICE POLICIES

Dr. ________________________________ and staff are dedicated to providing you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and practice.

Participating Insurance
You must provide us with accurate insurance information and allow us to photocopy your insurance card. Any co-payments are due at the time of service. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. If a referral is required by your plan, it must be presented prior to services. You must ensure that the referral is made to the correct doctor, that it has not expired and that the number of visits have not expired. If you receive services without obtaining a required referral, you will be financially responsible for such services.

Self-Paying Patients
Payments for services are due when services are rendered. If we do not participate in your insurance plan, we will be happy to help you process your claim, and/or provide you with an itemized bill, once all fees are paid.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services not covered by my insurance plan, if I have not obtained and presented a valid referral at the time services are rendered. I agree to pay for services and tests not covered by my insurance plan's regulations and procedures. I also request that this information to apply to any/all insurance(s).

Patient Full Name ____

____ **Date** ______________________
Signature of Patient/Parent or Guardian

Notice of Privacy Practices Patient Acknowledgement
Authorization for Use/Disclose of PHI

Patient Name ____ Date of Birth _________________

Acknowledgement of Privacy Notice
I have received the practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

Authorization for Use/Disclose of Protected Health Information (PHI)
I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize Dr. _________________ and his staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Manner of Contact
In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

**** I Wish To Be Contacted in The Following Manner**
________ NO RESTRICTION (Okay to contact home and/or work and leave detailed message)
________ Restricted Method of Contact (Check all that apply)
________ Home ONLY Message To Return Call To Doctor's office
________ Work ONLY Message To Return Call To Doctor's office
________ Other ____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Signature ______________________________________ **Date** ____________________

Relationship to Patient, if signed by a personal representative i.e. parent, legal guardian, etc
____

PLEASE PRINT AND COMPLETE ALL SECTIONS — READ AND SIGN AT THE BOTTOM

Patient's Name ______________________________ Birth Date ____________________ Sex F/M
Social Security ______________________________ Marital Status ___________________________
Street Address ____ Phone# _________________
Patient's/Parent's Employer __________________________________ Work# _________________
Employer Street Address ____
Spouse/Parent Name and Address ______________________________ Phone# _________________
Family Physician ____ Phone# _________________
Address ____
Referring Physician (if different) _____________________________ Phone# _________________
Address ____

INSURANCE INFORMATION

Policyholder's Name ____ Birth Date _____________
Street Address ____ Phone# ________________
Name of Insurance Co. ____ Group# ________________
Address ____ Phone# ________________

SECONDARY INSURANCE INFORMATION

Policyholder's Name ____ Birth Date _____________
Street Address ____ Phone# ________________
Name of Insurance Co. ____ Group# ________________
Address ____ Phone# ________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize ______________________, M.D. to furnish all necessary information to my insurance carriers concerning my (or my dependent's) illness and treatment and I hereby assign to the physician or supplier all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any co-payment for the office visit as designated by my insurance carrier. I understand that it is my responsibility to ensure that procedures/surgeries are part of my contract with my insurance carrier and I am responsible for payment if my insurance carrier does not cover the designated procedure.

____
Signature **Date**

FOR MEDICARE PATIENTS: I hereby authorize ________________________, M.D. to furnish all necessary information to my insurance carriers concerning my illness and treatment, and I hereby assign to the physician or supplier all payments for medical services rendered to me.

____
Signature **Date**

Acknowledgements, Agreements, Disclosures and Informed Consent

I, ___________________________________, (Patient's Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: Cancer, HIV/AIDS, Epilepsy, Multiple Sclerosis, Parkinson's disease, ALS (Lou Gehrig's disease), damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity (any spinal cord injury), Inflammatory Bowel Disease, Huntington's disease, any type of neuropathy; any condition that is severe, for which other medical treatments have been ineffective, and if the symptoms "reasonably can be expected to be relieved" by the use of medical cannabis. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)

- If not alleviated, may cause harm to the patient's safety or physical or mental health

- A chronic or debilitating disease or medical condition that causes severe loss of appetite, wasting, severe or chronic pain, severe nausea, seizures or severe or persistent muscle spasms, or glaucoma or post-traumatic stress disorder (PTSD)

I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery, drive or engage in potentially hazardous activities.

I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana may include but are not limited to: euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia, and increased eating.

I understand that some patients may become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms may include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

I understand that chronic use of medical marijuana may lead to laryngitis, bronchitis and general apathy.

I understand that although marijuana does not produce a specific psychosis, it may exacerbate schizophrenia in persons predisposed to that disorder.

I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition.

I understand there are few known interactions between marijuana and medications other than herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements or other medications.

I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of Marijuana as a drug. I understand the significance of this fact.

I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

I understand should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report any such problems or effects to the attending physician.

Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers in the lungs, mouth and tongue. I have been advised that medical marijuana smoke contain chemicals known as tars that may be harmful to my health. I understand that there are many methods of intake that substantially reduce the harmful effects of smoking such as vaporizers, edibles, tinctures, etc.

I understand marijuana varies in potency. The effects of marijuana may also vary with the delivery method. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, heart rhythm disturbances, numbness in the limbs, anxiety attacks and incapacitation.

If I start taking medical marijuana, I agree to tell my attending physician if I: start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking.

I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

I understand that I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

I am not permitted to smoke within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

I agree to follow up with the attending physician at ________________________________ with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of ________________________________ are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

I certify that I have read this document and declare under penalty of perjury that the information contained herein is true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form, the letter of recommendation will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, the above-mentioned activities will be reported to the appropriate local authorities.

The physician, staff and representatives of ________________________________ are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

Patient Signature: ____ Date: ____________________________

Release of Liability

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize ____ to converse of my medical condition.

I understand that I must be a **Florida** resident to obtain an approval or recommendation for the use of medical cannabis.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

Florida's Medical Marijuana Legalization Initiative – **Amendment 2, approved November 08, 2016** – provides for the possession of medical marijuana for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of medical marijuana.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

Patient Signature ____ **Date** ____________________________

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana.

I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality.

I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize MarijuanaDoctors.com or it's representative, to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success or failure.

I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above-mentioned regardless of whether or not I qualify as a patient.

Patient Name (Print) ________________________________ **Telephone#** _________________________

Patient Signature __________________________________ **Alt. Phone#** _________________________

Current Address

____

City __________________________________ **State** _____________________ **Zip** _____________________

HIPAA Notice of Privacy Practices Acknowledgement of Receipt

By signing this, I hereby acknowledge that I have read and understand the privacy practice notice and may obtain additional copies upon my request. This acknowledgement will be filed with my records.

Authorization for Release of Confidential Records

I,____, date of birth ____________________________, hereby authorize MarijuanaDoctors to disclose and verify me as a patient to any law enforcement agency, my physician(s), Child Protective Services or any _________________ State approved dispensary. This is valid during the period of time for which the recommendation has been issued. This consent is subject to written revocation only, at any time except to the extent that action has already been taken on the basis of this consent.

I give MarijuanaDoctors and the attending physician permission to validate my status as a patient using the MarijuanaDoctors online patient verification system.

I give permission for my medical records and file to be reviewed by another physician working with MarijuanaDoctors. I understand that this might happen if the original doctor that evaluated me requires a secondary opinion, is not available, off premise, has moved or terminated his/her practice.

DO NOT SIGN BELOW THIS LINE

I have asked the patient if he/she has any questions regarding his/her treatment with medical marijuana. I have answered those questions to the best of my ability.

Patient Signature _______________________________________ **Date** ___________________________

FLORIDA INITIAL TREATMENT PLAN

(To be completed by the provider)

Date of treatment plan submission ______________________________

PATIENT INFORMATION

Patient Registry ID Number ______________________ Patient Zip Code ________________

Patient DOB ___________________________ Race/Ethnicity ________________________

PROVIDER INFORMATION

Name ______________________ Address ______________________________

NPI# _________________ DEA# _________________ Medical License # __________________

Facility Name ______________________________ Phone# ___________________________

Specialty/Board Certifications ______________________________

Concurring Physician If Patient < 18 Years ______________________________

CANNABIS ORDER

Date of Order ______________________________ Dose _____________________________

Type of Administration _________________________ Planned Duration _________________

CLINICAL HISTORY and CONDITION

Indication(s) for cannabis treatment

Chief complaint for evaluation of cannabis treatment

List of Symptoms Type/Severity/Duration/Frequency of Onset

1. ______________________________
2. ______________________________
3. ______________________________

Prior treatment(s), duration of each attempted treatment and its outcome

____

____

Social Hx

EtOH Y/N *If yes, how often* ______________________________

Smoking Y/N *If yes, how much per day* ______________________________

Illicit Drugs Y/N *If yes, what type(s) and how often* ______________________________

Patient's Co-Morbidities/Disease History (circle all that apply)

Weight loss, hepatitis, rheumatic fever, mono, flu, arthritis, Ca, gout, asthma/COPD, pneumonia, thyroid dx, blood dycrasias, ASCVD, HTN, UTIs, DM, seizures, operations, injuries, PUD/GERD, hospitalizations, psych hx, OTHER ___________________________________

Current Medications

Psychoactive Medications

Med Name	Dosage	Regimen (e.g., one BID)	Target Symptoms

Other RX Medications

Med Name	Dosage	Regimen (e.g., one BID)	Target Symptoms

OTC/Supplements/Herbals/Other Self-Medication

Med Name	Dosage	Regimen (e.g., one BID)	Target Symptoms

Plan

Goals

Monitoring Plan of Patient's Symptoms

Planned Follow-Up Encounter Date

Considering your total clinical experience with this particular population, how ill is the patient at this time? (*Check the most appropriate response*)

❑ 1=normal, not at all ill ❑ 2=borderline ill ❑ 3=mildly ill ❑ 4=moderately ill

❑ 5=markedly ill ❑ 6=severely ill ❑ 7=among the most extremely ill patients

FLORIDA FOLLOW-UP TREATMENT PLAN

(To be completed by the provider)

Date of treatment plan submission ______________________________

PATIENT INFORMATION

Patient Registry ID Number ____________________ Patient Zip Code ______________

Patient DOB ______________________ Race/Ethnicity ______________________

PROVIDER INFORMATION

Name __________________ Address __________________________________

NPI# ______________ DEA# ______________ Medical License # _______________

Facility Name _________________________ Phone# ______________________

Specialty/Board Certifications ____

Concurring Physician If Patient < 18 Years __________________________________

CANNABIS ORDER

Any change in Drug Order since submission of last treatment plan? Y/N

(If yes, please explain)

CLINICAL HISTORY and CONDITION

Indication(s) for cannabis treatment

Any change in the Chief complaint for evaluation of cannabis treatment since last treatment plan?

Y/N *(If yes please explain)*

List of Symptoms Type/Severity/Duration/Frequency of Onset

1. ____
2. ____
3. ____

Patient's Co-Morbidities/Disease History

Any change in patient's co-morbidities since last treatment plan? Y/N *(If yes, please explain)*

____

Current Medications

Any change in current medications since last treatment plan (i.e., psychoactive Rx, OTC, Supplements, Herbals, Other Self Medication)? Y/N *(If yes, please explain)*

____

Were There Indicators of Intolerance or Reaction to Cannabis?

Were there any ADRs to cannabis, patient-reported problems, medication holds, ER visits, or hospitalizations? Y/N *(If yes, please explain)* ____

Plan

Are there any changes in goals of treatment, monitoring plan of patient's symptoms since the submission of the last treatment plan? Y/N *(If yes, please explain)* __________________________

____

Compared to the patient's condition at initiation of cannabis [prior to medication initiation], this patient's condition is: (*Check the most appropriate response*)

❑ 1=normal, not at all ill ❑ 2=borderline ill ❑ 3=mildly ill ❑ 4=moderately ill

❑ 5=markedly ill ❑ 6=severely ill ❑ 7=among the most extremely ill patients