Greene Family Medicine, APMC

MEDICAL MARIJUANA POLICY

FORM 08 2018 -1 ©

Welcome, in order for Craig H Greene, MD to accept you as a medical marijuana patient, you must be aware of the following:

1. **Please see your regular treating medical provider for the illness/condition that is covered for medical marijuana and you may obtain your completed marijuana consultation request (see attached) with your medical records as stated. Pediatricians referrals will be required for Autism Spectrum disorder.**
2. **Bring this form along with the attached medical forms with you on your first consult.**
3. **At your consult appointment, further information may be requested and general information concerning the process, procedures and cost will follow. Initial visit fee is $200.00 including a urine drug screening, all visits after the initial visit is $100.00. Call or go through our Patient Portal 1 week in advance for refill with no dosage change. If requesting dosage change, a face to face appointment will be required.**
4. **Appointment: We do not take walk ins. An appointment must be scheduled in advance with a 24 hours notice for rescheduling. $50.00 will be charged for no shows.**
5. **Forms: Work excuses, school excuses are free of charge**

   FMLA form or possible insurance forms will be charged $25.00

   Legal forms range from $50.00 to $100.00
6. **Payment: Insurance does not cover for service. We only accept Cash and Money Orders.**
7. **Urine Drug Screening: Random drug screening required in addition to the initial drug screening. Random drug screening costs $25.00.**
8. **You must be a legal Louisiana Resident to obtain the recommendation letter. Bring a valid Louisiana ID.**

Patient Name: (Print Please)_____ Date of Birth:_____ Age:_____

Address: _____

City:_____ St :_____ Zip:_____

Physical Address: Same ☐ If different from mailing address: _____

City:_____ St :_____ Zip: _____

Phone:_____ Cell Phone:_____

Sex: M F Marital Status: S M W D Race: White Black Asian Hispanic Other:_____

Notify in case of Emergency:_____ Relationship:_____ Phone: _____

I authorize Craig H Greene to review my medical records and access my medication(s) through the prescription monitor program for the purpose of reviewing my medical history as per the State of Louisiana Medical Marijuana Program requirements. I understand if it is requested and / or, if any condition necessitates, any release(s), additional testing, lab work, consultation, examination, office visit, etc. from any other provider, I am solely responsible for any and all financial responsibilities required in obtaining the requested release(s) and or documentation.

I have read, understand and agree to these clinic and payment policies.

Signature of Patient:_____ Date: _____