Cannabis Doc

PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

DATE:_____

_____ ☐ **MALE** ☐ **FEMALE**

LAST NAME **FIRST NAME** **MIDDLE INITIAL**

_____/_____/_____ _____ **ARE YOU PREGNANT** ☐ **YES** ☐ **NO** _____/_____/_____

DATE OF BIRTH **WEIGHT** **SOCIAL SECURITY NUMBER**

_____ (_____)_____

EMAIL ADDRESS **PREFERRED PHONE NUMBER**

OK TO SEND MEDICAL INFORMATION VIA EMAIL? ☐ **YES** ☐ **NO** **OK TO CONTACT/LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

_____

HOW DID YOU HEAR ABOUT US **(BILLBOARD, DISPENSARY, GOOGLE, etc.)**

_____

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

AILMENTS – MARK ALL THAT APPLY

- ☐ ALS (LOU GEHRIG'S)
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTHRITIS
  - ☐ RHEUMATOID
  - ☐ NON-RHEUMATOID
- ☐ BACK PAIN
- ☐ CAHCEXIA
- ☐ CARDIOVASCULAR DISEASE
- ☐ CANCER
- ☐ CHRONIC ABDOMINAL PAIN
- ☐ CROHN'S DISEASE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT NAUSEA/VOMITING
- ☐ GLAUCOMA
- ☐ HEPATITIS C
- ☐ HIGH BLOOD PRESSURE/HYPERTENSION
- ☐ HIGH CHOLESTEROL
- ☐ HIV/AIDS
- ☐ INFECTIOUS DISEASE
- ☐ IRRITABLE BOWEL SYNDROME (IBS)
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ LYME DISEASE
- ☐ MENOPAUSE
- ☐ MIGRAINES
- ☐ MUSCLE SPASMS
- ☐ MUSCULAR DYSTROPHY
- ☐ MULTIPLE SCLEROSIS
- ☐ NEUROLOGICAL DISORDER
- ☐ OBESITY
- ☐ PAIN – SEVERE/CHRONIC
- ☐ PARKINSON'S DISEASE
- ☐ PTSD
- ☐ SICKLE CELL ANEMIA
- ☐ SKIN DISORDERS
- ☐ SPASTICITY
- ☐ STROKE – WHEN?_____
- ☐ OTHER:_____

DESCRIBE SYMPTOMS:

SEVERITY: ☐ **MILD** ☐ **MODERATE** ☐ **SEVERE**

HOW EFFECTIVE WERE PRIOR TREATMENTS FOR YOUR CONDITION(S)? ☐ **VERY EFFECTIVE** ☐ **EFFECTIVE**

☐ **SOMEWHAT EFFECTIVE** ☐ **NOT EFFECTIVE** ☐ **N/A**

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PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

PATIENT NAME:____AGE________DATE:________________________

SURGICAL HISTORY

ALLERGIES (MEDICATIONS, PRODUCTS AND/OR FOODS)

____

____

____

____

MEDICATIONS

MEDICATION/ DOSAGE	PER DAY	REASON
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____

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PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

PATIENT NAME:_____**AGE**_____**DATE:**_____

CANNABIS HISTORY

HOW EFFECTIVE IS THE USE OF CANNABIS FOR YOUR CONDITION? ☐**VERY EFFECTIVE** ☐**EFFECTIVE** ☐**SOMEWHAT EFFECTIVE** ☐**N/A**

HAVE YOU EVER HAD AN ADVERSE REACTION TO CANNABIS? ☐**YES** ☐**NO** ☐**N/A**

HAVE YOU EVER OR DO YOU HAVE A MEDICAL CANNABIS RECOMMENDATION? ☐**NEVER** ☐**PREVIOUSLY** ☐**CURRENTLY**

SUMMIT WELLNESS WILL BE YOUR CERTIFIED PROVIDER FOR MEDICAL CANNABIS BUT WILL NOT ASSUME RESPONSIBILITY FOR ANY OTHER MEDICAL NEEDS.

SUMMIT WELLNESS DOES NOT ACCEPT INSURANCE AND WILL NOT BILL FOR SERVICES.

_____ ___/___/_____

PATIENT SIGNATURE DATE

_____ ___/___/_____

DOCTOR SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

(TO BE READ AND SIGNED BY PATIENT)

Summit Wellness is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from this office. The creation of a record detailing the care and services you receive helps this office to provide you with high quality care. This Notice also details your rights regarding your PHI.

Without consent required, Summit Wellness may use and/or disclose your PHI for the purposes of:

- TREATMENT: In order to provide you with the health care you require this office will provide your PHI to those health care professionals, whether with Summit Wellness or not, directly involved in your care so that they may understand your health conditions and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office. Also, your Summit Wellness provider may register as your ordering physician with the State of Florida Medical Marijuana Use Registry.
- PAYMENT: In order to receive payment for services provided to you, this office may provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements.
- HEALTHCARE OPERATIONS: Summit Wellness may use and disclose PHI for healthcare operations. These uses and disclosures are necessary to operate Summit Wellness and to make sure that office patients receive appropriate care. For example, this office may use medical information to review treatments and services and to evaluate the performance of providers and the care provided patients.
- AS REQUIRED BY LAW: Summit Wellness will disclose PHI when required to do so by federal, state or local law.

Other Permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, this office is expressly prohibited to use or disclose your PHI for marketing purposes. Summit Wellness may not sell your PHI without your authorization. You may revoke this authorization, at any time, in writing except to the extent that this office has taken an action in reliance on the authorization.

Your rights with respect to your PHI:

- You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your PHI. This means that you may ask Summit Wellness not to use or disclose any part of your PHI for the purposes of treatment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Summit Wellness is not required to agree to a restriction that you may request. If your Summit Wellness physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another service provider.

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NOTICE OF PRIVACY PRACTICES

(TO BE READ AND SIGNED BY PATIENT)

- You have the right to request to receive confidential communications from this office by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from Summit Wellness, upon request, even if you agreed to accept this notice alternatively, e.g., electronically.
- You have the right to request an amendment to your PHI. If Summit Wellness denies your request for amendment, you have the right to file a statement of disagreement and Summit Wellness may prepare a rebuttal.
- You have the right to receive an accounting of certain disclosures this office has made, if any, of your PHI.

Summit Wellness reserves the right to change this notice and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect. Summit Wellness will inform you of any significant changes to this notice. You then have the right to object or withdraw as provided in this notice.

Breach of PHI:

- Summit Wellness will notify you if a reportable breach is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the PHI involved and contact information for you to ask questions.

Complaints:

- Complaints about this Notice or how Summit Wellness handles your PHI should be directed to the Summit Wellness HIPAA Compliance Officer. If you are not satisfied with the manner.
- This notice was originally published and effective on February 1, 2017. in which a complaint is handled you may submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights. Summit Wellness will not retaliate against you for filing a complaint.
- Summit Wellness is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please ask to speak with the HIPAA Compliance Officer.

Signature below is acknowledgement that you have received or been given opportunity to receive this Notice of Privacy Practices:

Printed Name:_____

Patient Signature:_____ DATE:_____/_____/_____

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CONSENT TO TREATMENT

(TO BE READ AND SIGNED BY PATIENT)

I hereby authorize Summit Wellness and its personnel (hereby referred to as the "Provider's Personnel") to examine and evaluate my medical condition and, based on the findings of that examination and evaluation, to:

- Determine that I qualify for the use of low-THC or medical cannabis, order my use of low-THC or medical cannabis, and add my name to the medical marijuana use registry;

  And/or

- Certify that I qualify for the medical use of marijuana.

The Provider's Personnel presented me with this written Consent to Treatment explaining:

- The therapies and treatments that will be provided to me;
- That the therapies and treatments appear to be indicated by the results of my examination and evaluation;
- The substantial risks and hazards associated with each such therapy and treatment, specifically including the potential benefits versus the potential risks of using low-THC cannabis, medical cannabis, and marijuana;
- The medically acceptable alternatives to each therapy and treatment, if and to the extent acceptable alternatives exist;
- That there is a lack of scientific data regarding the potential danger of long term use of low-THC cannabis, medical cannabis, or marijuana;
- That there is no guarantee with respect to the benefits that I may or may not realize from the therapies and treatments referred to above; and
- That the possession and use of marijuana violates Federal Law.

I have read this Consent to Treatment, and have had the opportunity to have all of my questions answered by the Provider's Personnel with respect to the treatments and therapies referred to above. I fully understand this form and am signing it voluntarily.

PATIENT:

_____

Signature

_____

Print Name

_____

Date