337-565-2239 Visit Chermd.com

GreenRx
Cher Aymond MD

• Medical Marijuana Consultation • CBD Oil
• Medical Clinic • Weight Loss

4605 N. University Ave, Carencro Near Chase

MEDICAL MARIJUANA POLICY

Welcome, in order for Dr. Cher Aymond to accept you as a medical marijuana patient, you will need to provide the following:

1. **Please see your regular treating provider for the illness/condition that is covered for medical marijuana and obtain your medical records as stated.**
2. **Mail this signed and dated form, the past medical history form, the release of liability & declaration form and a copy of your medical records for review to:**

   Dr. Cher Aymond, MD ***you can drop medical record on business hours
   4605 N University Ave ***you can EMAIL to doc@chermd.com --OR—FAX to 337-570-1251.
   Carencro, LA 70520 **Business hours: Tuesdays & Thursdays 9 M TO 4 PM**

3. **Upon receipt of your paperwork & your medical records (copies only acceptable), they will be reviewed and a decision of acceptance or no acceptance into the program will be determined. (please, copies of records are not returnable and will be destroyed if you are not accepted)**
4. **If you do qualify and are accepted your initial appointment will be scheduled. Drug screens may be required during your treatment on a random basis. You will also be required to have follow-up appointments as doctor orders.**

PLEASE NOTE: ALL APPOINTMENTS, REFILL REQUEST, AND DRUG SCREENS MUST BE PAID AT TIME OF SERVICE. INITIAL VISIT $180.00, FOLLOW-UP VISIT $125.00, REFILL REQUEST $30.00, AND DRUG SCREENS RANGE FROM $25-$50. WE DO NOT FILE INSURANCE. **CASH OR CREDIT CARD ONLY**

Health Insurance is not applicable for marijuana consultations at this time

Currently, the following are the only qualifying conditions we accept in the program:

Please check the Qualifying Condition:

☐ HIV/AIDS	☐ Cancer	☐ Cachexia/Wasting Syndrome
☐ Dystrophy/Multiple Sclerosis	☐ Spasticity	☐ Glaucoma
☐ Seizures/Epilepsy	☐ Parkinson's disease	☐ Crohn's Disease
☐ Intractable (Chronic) Pain	☐ Other: _____	

Patient Name :(please print)_____**Date of Birth:**_____**Age:**_____

Address:_____

City: _____**State:**_____**Zip:**_____

Physical Address: Same ☐ **If Different:**_____

Home Phone:_____**Cell Phone:**_____

Email Address:_____**Best Way to Contact:**_____

Emergency Contact: _____**Relationship:**_____**Phone:**_____

Sex: ___ F ___ M Marital Status: S M W D Race: ___ White __Black ___Asian ___Hispanic ____Other

I authorize Dr Cher Aymond to review my medical records and access my medications through the prescription monitor program for the purpose of reviewing my medical history as per State of Louisiana Medical Marijuana Program requirements. I understand if it is requested and/or, if any condition necessitates, any release(s), copies of records, 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 releases or documentation

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

Signature of Patient: _____ **Date:**_____