## PATIENT INFORMATION

**First Name:_____Middle Name:_____Last Name:_____**

**Date of Birth:_____Sex: F____ M_____ Other_____**

## CONTACT INFORMATION

**Address: _____**

**City:_____ State _____ Zip _____**

**Mobile Phone: _____ Secondary Phone: _____**

**Email: _____**

**Consent for text and voice messages: YES_____ NO _____**

**Preferred Language: English_____ Other_____**

**Ethnicity/Race: American Indian _____ Native Hawaiian or other Pacific Islander_____**

**Hispanic___ Asian____ African Americian ____ White ____ Other_____**

**Pharmacy Name: _____ Contact Number:_____**

**Address (corner it is located): _____**

## INSURANCE INFORMATION

**Insurance Company Name: _____**

**ID Number:_____ Group Number: _____**

**Insured Name_____ Insured Date of Birth:_____**

**Relation to patient: _____**

## EMERGENCY CONTACT INFORMATION

**First Name:_____ Last Name:_____**

**Mobile Phone: _____**

**Relation to Patient: _____Authorized to Release Medical Information:Yes__No__**

## Please list any other names of family member and/or medical professionals to whom your medical information may be released:

| Name | Phone Number | Relationship/Specialty |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

:

**Green Rx** Cher Aymond MD

# PAST MEDICAL HISTORY

| PATIENT | DATE OF BIRTH |
|---|---|
| EMAIL ADDRESS | CELL PHONE |
| PREFERRED CONTACT METHOD<br>☐ TEXT ☐ PHONE ☐ EMAIL | LOUISIANA DRIVERS IDENTIFICATION #<br>OR STATE ISSUED ID # |

**List any medications and dosage you are currently taking (prescription and non-prescription) please use blank page if needed:**

| **NAME**<br>*Example: Aspirin* | **DOSAGE**<br>*325 mg* | **FREQUENCY**<br>*Once a day* | **DOCTOR**<br>*Doctor's Name* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list any drug allergies and describe (prescription and non-prescription):**

| |
|---|
| |
| |
| |

**Please check ✓ if any of the following activities are substantially limited or impaired**

| | | | |
|---|---|---|---|
| | Bending | | Breathing |
| | Caring for myself | | Communicating |
| | Concentrating | | Eating |
| | Lifting | | Operation of major bodily functions |
| | Performing manual task | | Reading |
| | Seeing | | Sleeping |
| | Social Interaction | | Speaking |
| | Standing | | Thinking |
| | Walking | | Working |

**Please list any additional information you consider relevant to the physician's evaluation**

| |
|---|
| |
| |
| |

**Please list any Surgical History**

| |
|---|
| |
| |

**Green Rx** Cher Aymond MD

# PAST MEDICAL HISTORY

| |
|---|
| Do you require assistance in activities of Daily Living<br>☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed |
| Are you currently taking CBD Oil? ☐ Yes ☐ NO If yes, Do you experience any side effects from CDB ? ☐ Yes ☐ NO |
| List any Side Effects: |

**Please circle the current symptom(s) you may have, you may select multiple options**

| | | | |
|---|---|---|---|
| Abdominal Pain | Mild | Moderate | Severe |
| Anxiety | Mild | Moderate | Severe |
| Joint Pain | Mild | Moderate | Severe |
| Muscle Spasm | Mild | Moderate | Severe |
| Poor Appetite | Mild | Moderate | Severe |
| Nausea / Vomiting | Mild | Moderate | Severe |
| Disturbing Feelings | Mild | Moderate | Severe |
| Depression | Mild | Moderate | Severe |
| Constipation | Mild | Moderate | Severe |

**Please check ✓ Yes of No**

| | YES | NO |
|---|---|---|
| Do you smoke tobacco | | |
| Do you understand smoking is harmful to your lungs and is not medically advised | | |
| Have you used Cannabis in the past to treat your medical condition(s) | | |
| Have you had any negative / adverse reactions from cannabis use | | |
| If yes, Please specify: | | |
| | | |
| Do you have a history of addiction and / or drug abuse | | |
| If yes, Please specify the drug(s): | | |
| | | |
| Do you have a history of mental Illness | | |
| Do you have a history of mental illness in your immediate family, Parents, Grandparents, Brother / Sister | | |
| If yes, Please specify condition(s): | | |
| Do you have any LEGAL CASES/CHARGES pending or active? | | |

**Please check ✓ preferred method of marijuana uses as a medicine**

| Preferred Treatment Method | ✓ | Preferred Treatment Method | ✓ |
|---|---|---|---|
| Capsules | | Nebulizer ( in future ) | |
| Oil Extract / Concentrate | | Tincture | |
| Topical Cream | | Vaporizer ( in future ) | |
| Other: | | | |

**Please circle your level of pain**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# 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 or distributing medical marijuana.

I attest that I am not a member, employer, 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 device 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 a medical record to the physician.

I acknowledge Cher Aymond MD 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 of failure.

I acknowledge Cher Aymond MD 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 conditions.

**Patient Signature** _____ **Date** _____

# Release of Liability

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 an improvement in my condition.

In requesting approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

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.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis s a medicine has been explained to me and that ay 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 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 physical to assess the possible continuance of cannabis use beyond the term of the approval.

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

**Patient Signature** _____ **Date** _____

# INFORMED CONSENT

I am being evaluated for a physician's recommendation for medical use of marijuana. 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 it only as needed for treatment of my medical condition, not for recreational or non medical purpose. 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 marijuana. I have been informed of and understand the following **[Please sign at the end of the form].**

1. The federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 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; (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as California, which have modified their state laws to treat marijuana as a medicine.

2. Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana 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.

3. The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, 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 marijuana, I can be arrested for "driving under the influence."

4. Potential side effects from the use of marijuana 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 skins, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my 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. Dr Cher Aymond recommends cannabis use for the relief of serious symptoms, and not for habitual use.

5. 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. Cannabis should be treated as an open container of alcohol. It should not be within reach in the car, and should not be extinguished in the vehicles ash tray. 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.

6. I agree to contact Dr Cher Aymond during business hours if I experience any of side effects listed above, or if I go to the ER, if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Dr Cher Aymond if I experience respiratory problems, change in my normal sleep patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

7. Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researches, marijuana smoke contains know carcinogens (chemical that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancer in the lung, mouth and tongue. In additions, marijuana smoke contains harmful chemical known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to my physicians.

8. The risk, benefits and drug interactions of marijuana are not fully understand. 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 marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

9. Individuals may develop a tolerance to, and/or dependence on, marijuana. 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, I should contact Dr Cher Aymond. It is recommended for patients to have an intermission with marijuana for at least 3 to 4 weeks every 3 to 4 months.

10. Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbance and unusual tiredness.

11. Symptoms of marijuana overdose include, but 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 Cher Aymond MD immediately or go to the nearest emergency room.

12. If Cher Aymond MD subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with Cher Aymond MD and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

13. I have 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 Cher Aymond MD has informed me to the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

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

_____ _____

**Patient Signature** **Date**

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS

Applicant Acknowledgment/Authorization for Use/Disclose of Protected Health Information and TMR recommendation information.

1. Acknowledgment of Privacy: HIPAA

   I acknowledge that I was provided access to the Notice of Privacy Health Practice (PHI). I understand I can obtain this practice's PHI notice upon request. I have been allowed the opportunity to ask questions, to submit a special written request, and to object to the release of my PHI to a specific person if I so choose.

   I understand Dr. Cher Aymond will not disclose my medical information that was obtained and brought into the office and that Dr. Chery Aymond requires me to keep copies of all medical records brought to the office and copies of TMR recommendation letters for potential legal issues.

2. Authorization for Disclosure: Therapeutic Marijuana Recommendation (TMR) Information

   I authorize the use and disclosure of my TMR information for the purpose of treatment and payment and healthcare operations. I authorized Dr. Cher Aymond and her staff to release to the following individuals and providers. I understand the information released to the following parties may be redisclosed to additional parties and no longer protected.

   List the persons that you are allowing this office to communicate with or allowing access of records regarding TMR.

| NAME | DOB | RELATIONSHIP | PHONE NUMBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

3. Authorization for Release of Confidential Records

   I authorize Dr. Cher Aymond to disclose and verify me as a TMR applicant to any law enforcement agency, child protection service or any state approved dispensary, valid for the period of recommendation issues. I give permission for my medical records and files to be reviewed by another physician(s) that you are working with. I understand that this might happen if the original doctor that evaluated me requires a second opinion, is not available, off premise, has moved, or terminated the practice.

4. Manner of Contact:

   I understand that this practice calls or texts to confirm appointments at the number I provided.

   Signature: _____ Date: _____

# Office Policy for Medical Marijuana Recommendation

## Appointment

We do not take walk ins. An appointment must be scheduled in advance with a 48 hour notice for rescheduling. $25 will be required for no shows and applicants will be considered voluntarily discharged from clinic if an appointment is missed twice.

## Forms

Work excuses, school excuses are free of charge.

FMLA form or possible insurance forms will be charged $25.

Legal forms range from $50 to $100.

## Payment

Insurance does not cover or reimburse for this service. Thus, we do not accept insurance. We accept credit card, debit card, HSA, and cash.

## What to Bring

Photo IDs: Driver's License, State ID card, Military ID, Passport.

You must be a Louisianan Resident to obtain the recommendation letter.