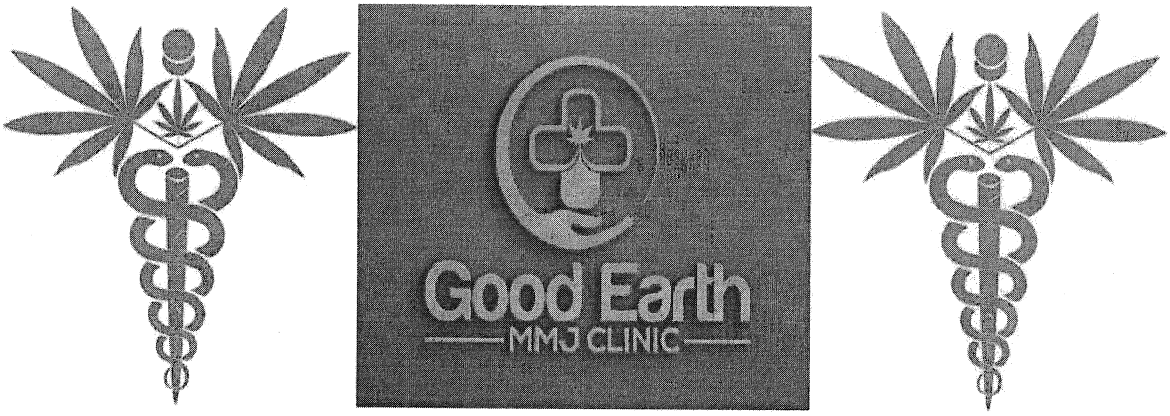

NEW PATIENT FORM

NAME_____ DATE OF BIRTH:_____ I AM OVER 18 YEARS OLD (YES/NO)
ADDRESS:_____
EMAIL:_____ CELLPHONE NUMBER_____
GENDER (MALE/FEMALE/OTHER)
TEXAS DRIVER LICENCE NUMBER_____
EMERGENCY CONTACT_____ EMERGENCY CONTACT PHONE_____
IF UNDER THE AGE OF 18, PLEASE LIST GURADIAN/CAREGIVER NAME:_____
GUARDIAN PHONE NUMBER_____RELATION TO PATIENT_____

WHO IS YOUR PRIMARY CARE PHYSICIAN

NAME_____

CLINIC_____

PHONE_____

WHEN WERE YOU DIAGNOSED?
YEAR_____

CURRENT MEDICATIONS FOR QUALIFYING DIAGNOSIS:

_____
_____
_____
_____
_____

List of Qualifying Conditions required

- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Alzheimer's Disease and other dementias
- ☐ Autism and other spectrum disorders
- ☐ CTE (Chronic Traumatic Encepatholpathy)
- ☐ Epilepsy and other seizure disorders
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Spasticity
- ☐ Cancer
- ☐ Peripheral Neuropathy
- ☐ Post Traumatic Stress Disorder
- ☐

Other_____

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☐ [QUALIFYING MEDICAL DIAGNOSIS RECORDS WILL BE REQUIRED AT TIME OF VISIT]
(LOS EXPEDIENTES DE DIAGNÓSTICO MÉDICO QUE CALIFICAN SERÁN REQUERIDOS AL MOMENTO DE LA VISITA)

Initial
(Inicial)

Medical Cannabis Acknowledgment of Disclosure & Informed Consent

Please be advised of the of the following: INITAIL EACH BOX

Possession or use of this product is unlawful outside of the State of Texas.

Cannabis-based medicine may have intoxicating effects and has not been analyzed or approved by the united states Food and Drug Administration and was produced without FDA oversight for health, safety, or efficacy. Medical cannabis may contain unknown quantities of active ingredients, impurities or contaminants.

The efficacy and potency of cannabis may very widely depending on the cannabis strain and ingestion method.

If the cannabis is smoked or vaporized: Smoking may be hazardous to your health. Cannabis smoke contains carcinogens and may lead to an increased risk of cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.

If cannabis is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.

If cannabis is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more. Anxiety/Nervousness Irregular/Increased heart rate Numbness Agitation Poor physical condition Dizziness/Impairment of motor skills Dependency Impaired vision Laryngitis/Bronchitis/General Apathy Headache/Nausea/Vomiting Paranoia/Psychotic Symptoms

Symptoms of cannabis overdose include, but are not limited to, nausea, vomiting, and disturbances to heart rhythm.

This acknowledgment of disclosure is to advise you of risks and side effects of using cannabis medicines. It is important you review this document and discuss any questions you may have with the dispensary pharmacist..

- I confirm that all information given in this form is true, complete, and accurate.
- I released this organization for any responsibility in case of accident, illness, or injury.
- I acknowledge that no assurance was offered about the outcome.
- I acknowledge that I received an Informed Consent document and the health staff explained it to me thoroughly.

Please do not sign this agreement if you do not understand the information you have received or not comfortable with the risks that may be related to cannabis use or possession.

Signature of Patient/ Parent or Legal Guardian/Caregiver_____

Date _____

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Medical Cannabis Patient Agreement

I agree that the following statements are true and accurate:

I am over 18 years of age and I am registered with and understand the requirements of the State of Texas medical cannabis program.

I agree to strictly comply with the regulations, terms and conditions of the State of Texas medical marijuana program. No cannabis obtained by me shall be used for any other purpose than as directed by my certifying physician. I understand cannabis is not to be resold, distributed, or used by any other person.

I fully accept the responsibility in using cannabis and I certify I fully understand the potential risks related to the use of cannabis products.

If I start using cannabis, I agree to tell my physician if I experience any one or more of the following:

- Start to feel sad or have crying spells
- Have changes in my normal sleep patterns
- Lose my appetite
- Become more irritable than usual
- Become unusually tired
- Withdrawl from my family and friends
- Lose interest in your usual activities

In the event that I experience a severe adverse reaction, I am advised to immediately contact my physician. In the event that my physician is not available, I agree to call 911 for help, lie down and relax until help arrives.

Signature of Patient/ Parent or Legal Guardian/Caregiver required_____

Date Signed required

Privacy Policy and Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE:

GOOD EARTH MMJ CLINIC (hereto referred as "GEMC"), and its faculty, employees, and non-employees follow the privacy practices described in this Notice to maintain your health information in records that are kept in a confidential manner, as required by law. GEMC must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations:

GEMC has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with radiologists or other consultants to make a diagnosis. GEMC may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, GEMC may use and disclose your health information to improve the quality of care, and for education and training purposes of GEMC residents and faculty.

How will GEMC Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*)

- GEMC directories, which may include your name, general condition, and your location in GEMC. (*)
- Family members of close friends involved in your care or payment for treatment. (*)
- Disaster relief agency if you are involved in your care or payment for treatment. (*)
- To inform you of treatment alternatives or benefits or services related to your health. (*)
- Appointment reminders.
- Public health activities, including disease prevention, injury, or disability; reporting births and deaths;
- reporting reactions to medications or product problems; notification of recalls; infectious disease control;
- notifying government authorities of suspected abuse, neglect, or domestic violence.
- Health oversight activities, such as, audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state, or local law.
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or other
- lawful request.
- Coroners, medical examiners, and funeral directors.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of the foreign
- military authority.
- National Security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
- To carry out health care treatment, payment and operations functions through business associates, such as to install a new computer system.

Your Authorization is Required for Other Disclosures. Except as described above, we will not use or disclose your medical information, unless you allow GEMC in writing to do so. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

Alcohol and drug abuse information has special privacy protections. GEMC will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or, as required by law.

You Have Rights Regarding Your Health Information. You have the following rights regarding your medical information, if requested on the form(s) provided by GEMC:

- Right to Request Restriction. You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not.
- Right to Confidential Communications. You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electric copy of this Notice in our office.
- Requirements Regarding this Notice. GEMC is required by law to provide you with this Notice. We will comply with this Notice for as long as it is effect. GEMC may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future.

Each time you register at GEMC for health services, you may receive a copy of the Notice in effect at this time.

CONTACT GEMC AT (830) 582-8333 IF:

- You have any questions about this notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

I ACKNOWLEDGE THAT I HAVE RECIEVED AND UNDERSTAND THIS HIPPA NOTICE AND MAY REQUEST A COPY AT ANY TIME.
Signature of Patient/ Parent or Legal Guardian/Caregiver required_____
Date Signed required

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