Dear Patient,

Thank you for booking with Good Earth MMJ Clinic. To prevent cancellation and help speed up the screening process during your appointment, please make sure you have reviewed our website Goodearth210.com and are familiar with the qualifying diagnoses and required documentation as required by the State of Texas.

We have also attached the New Patient Registration Forms for your convenience.

PLEASE REVIEW. INFORMATION BELOW AND REPLY TO THIS EMAIL WITH "I AGREE" PRIOR JO YQUR VISIT WITH DR ALTAM!RANQ PLEASE NOTE TH\S HAS IQ BE DONE PR!OR JO YOUR SCHEDULED APPOINTMENT. **NO EXCEPTIONS**

BY REPLYING "1 AGREE." TO THIS EMAIL YQ.u AGREE TO THE TERMS BELOW,

*To get certified I will need a Texas Driver's License or State-issued ID Card.

*I understand I need to provide medical proof of my condition at the time of visit to prevent cancellation.

Proof includes ANY of the following:

- MEDICAL RECORDS ◦ pill bottles ◦ prescriptions ◦ office visit notes
  - ◦ letter/note from your doctor
  - ◦ X-ray (radiographic) reports that clearly state your name and the condition/injury

*lunderstand that Dr. Altamirano is not my primary care physician NOR will diagnose me for the qualifying condition. My primary care physician must make that diagnosis, and Dr. Altamirano manages Compassionate Use of Cannabis ONLY.

*I understand I will have an initial office visit (COST $220) and a REQUIRED follow up in 3 months ($100).

*I understand that during my follow up we will fine tune my dose, type of cannabis product, and send refills to the dispensary. After this follow-up, I may NOT need to see Dr A again until it is time to recertify at the I-year mark.

*I understand that if I need to see Dr. A for any changes, this will incur in a follow up visit ($100) each time.

*I understand I will need to recertify at the one year mark.

*I understand that after initial office visit with Dr. Altamirano, I will need to contact one of the dispensaries below to fill my prescription.

GOODBLEND (512) 351-4600

TEXAS ORIGINAL (512) 614-0343

*I understand that PAYMENT '$ DUE AT THE TIME OF VISIT.

Patient Signature:_____ Date:_____