Bucyrus Internal Medicine, Inc.
Medical Marijuana Acknowledgement of Disclosure and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree with the information regarding the risks and side effects of using Medical Marijuana. Do not sign this agreement and do not use Medical Marijuana if you have questions about or do not understand the information you have received. Please tell us if you do not understand any of the information provided.

Patient's Name _____DOB____/____/____

Address_____

City _____State Ohio_____ Zip Code _____

Physician Obtaining Consent:_____**Dr. Roy W. Harris, DO, FACOI**_____.
Bucyrus Internal Medicine, Inc.
510 Hill Street Bucyrus, OH 44820
Phone 419-562-9834

ATTENTION:

I am being evaluated for a physician's recommendation for Medical Marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical Marijuana only as needed for the treatment of my medical condition, not for recreational or non- medical purposes. 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 Medical Marijuana. I have been informed of and understand the following:

1. I understand that possession or use of Medical Marijuana is unlawful under Federal law and outside of the state of Ohio. I also understand that possession or use of Medical Marijuana is unlawful within the state of Ohio if not recommended for medical purposes by a licensed medical doctor with the legal ability to do so. _____initial

2. Certain forms of Medical Marijuana 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 Marijuana may contain unknown quantities of active ingredients, impurities, or contaminants. _____initial

3. A physician-patient relationship shall be established and maintained for the provision of medical service for the recommendation of Medical Marijuana by an in person visit and documentation maintained in a medical record concerning all visits. Medical records shall be retained per state law guidelines at Bucyrus Internal Medicine, Inc. _____initial

4. The efficacy and potency of Medical Marijuana may vary widely depending on the strain and ingestion method. _____initial

5. If Medical Marijuana is vaporized: Such use may be hazardous to your health. Medical Marijuana contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease. _____initial

6. If Medical Marijuana 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. _____initial

7. There is limited information on the side effects of using Medical Marijuana, and there may be associated health risks. _____initial

8. For some patients, chronic Medical Marijuana usage can lead to laryngitis, bronchitis, and general apathy (lack of interest or inability to feel normal). _____initial

9. I have been further advised that some forms of Medical Marijuana may contain chemicals known as tars that may be harmful to my health. _____initial

10. I understand side effects of Medical Marijuana can include but are not limited to: Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, Poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation. _____initial

11. The scientific basis for the medical use of Medical Marijuana is not complete. There is little known regarding how Medical Marijuana may, or may not, react with other pharmaceutical or herbal medications. _____initial

12. Some patients can become dependent on Medical Marijuana. This means they experience withdrawal symptoms when they stop using Medical Marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite. _____initial

13. Some users develop a tolerance/ dependence to Medical Marijuana. This means higher and higher doses are required to achieve the same symptom relief. I may be developing a dependency on marijuana, I should contact my primary care physician. _____initial

14. The possibility exists that Medical Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. _____initial

15. Women should not consume Medical Marijuana while planning to become pregnant, during pregnancy, or while breast feeding. In the case of breast feeding mothers, on the advice of the infant's pediatrician. _____initial

16. Using Medical Marijuana while under the influence of alcohol is not recommended because additional side effects may become present. _____initial

17. The use of Medical Marijuana may affect coordination, cognition, and judgment. While under the influence of Medical Marijuana, do not to drive, operate machinery, or engage in potentially hazardous activities. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."_____initial

18. Please note that Medical Marijuana will degrade over time. _____initial

19. I understand the importance of securely storing medical marijuana to reduce the risk of exposure to children, pets, and others. I will not Share My Medical Marijuana with Others. _____initial

20. Medical marijuana shall not be possessed or administered at any public or private place where medical marijuana is prohibited, including but not limited to workplace and federal property. _____initial

21. Consequently, using or possessing marijuana and firearms at the same time is illegal, regardless of whether the state has passed legislation authorizing marijuana use for medicinal purposes. _____initial

Medical Marijuana Patient Agreement

1. I am over 18 years of age and understand the requirements of the State of Ohio's Medical Marijuana Program. If under 18 years, have signed a minor consent form obtained by patient's parent or legal representative. _____initial

2. I have been advised of the current state of knowledge in the medical community of the effectiveness of Medical Marijuana for the treatment of my condition. _____initial

3. I understand and have been advised of the potential side effects which may occur while I am taking Medical Marijuana. _____initial

4. Symptoms of Medical Marijuana overdose include but are not limited to nausea, vomiting, hacking cough and disturbances to heart rhythm, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to nearest Emergency Room. _____initial

5. In the event that I experience an side effects listed above, or I become depressed or psychotic, have suicidal thought, or experience crying spells, experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends, I am advised to contact my primary care physician. In the event my primary care physician is not available, I agree to call 911 for help and I am advised to lie down, relax, and rest until help arrives. _____initial

6. I have never had symptoms of schizophrenia or have been diagnosed as having schizophrenia by a physician or mental health professional. _____initial

7. I have no direct blood relatives (father, mother, siblings) that have had symptoms or has been diagnosed as having schizophrenia or has been psychotic. _____initial

8. I agree to tell my medical professional if I have ever had symptoms of schizophrenia, been psychotic or attempted suicide. I also agree to tell Dr. Harris, if I have ever been prescribed or taken medicine for any of these problems. _____initial

9. I am not pregnant, intending on becoming pregnant, or breastfeeding. _____initial

10. When under the influence and/or in possession of Medical Marijuana in public, your state issued Medical Marijuana ID Card or temporary state issued verification should be on your person at all times. _____initial

11. I understand I must give 48-hours' notice for cancellation of appointments. I further understand that 2 or more no calls/no shows within a calendar year will result in my discharge from the practice as well as revocation of Dr. Harris's patient recommendation for Medical Marijuana. _____initial

12. I understand there are certain requirements to remain in compliance with Ohio law regarding Medical Marijuana and may be updated at times. I will remain updated between visits by staying current with these changes. (Ohio Official Resource: Medical Marijuana Control Program) _____initial

13. I understand that the Ohio Board of Pharmacy may revoke my Medical Marijuana Card for any of the following:
    (a) The patient or legal representative makes material misrepresentations in his or her application.
    (b) The patient uses his or her card to obtain cannabis for another individual
    (c)The legal representative purchases, obtains, possesses, or uses cannabis not sold by an approved dispensing organization, or
    (d) The patient is no longer a qualified patient.
    (e) I am not in compliance with Ohio state law and regulations set forth (Ohio Official Resource: Medical Marijuana Control Program) _____initial

14. **I understand if I give dishonest or untruthful information, I will be discharged. If Dr. Harris learns that the information furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly provide additional information in the event of any inaccuracies or misstatements in the information I have provided.** _____initial

15. Dr. Roy Harris requires that I return for a Follow Up in 90 days after my initial appointment to review my medical condition and to evaluate my use of Medical Marijuana. Further Follow Ups make be scheduled at intervals of 3 months to 6 months. I will make sure to schedule my 90 day Follow Up before I leave Appointment. _____initial

16. I have been advised about other medically acceptable alternatives for my qualifying medical condition that do not involve the recommendation of medical marijuana. _____initial

17. I agree to continue regular medical FOLLOW-UP at my personal primary care physician's office. I understand that interaction with healthcare providers is in the best interest for my quality of care. **THIS IS VERY IMPORTANT**. _____initial

18. I understand that it is important to my health to be aware of the use of Medical Marijuana and have been given access to Bucyrus Internal Medicine, Inc. website (www.bucyrusim.com) to review education material. _____initial

Release of Liability

1. I hereby acknowledge Bucyrus Internal Medicine, Inc, and its employees are not addressing specific aspects of my medical care, but are evaluating my qualifying medical condition and medical history for recommendation for medical marijuana. I will continue to see my primary care provider for care for all my medical conditions. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Bucyrus Internal Medicine, Inc., and its principals, agents, and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals because of my Medical Marijuana use. _____initial

2. I certify that I fully understand the potential risks and side effects related to the use of Medical Marijuana as described above and had the opportunity to discuss these matters with Dr. Roy Harris and to ask questions regarding anything I may not understand or that I need clarified. _____initial

3. In using Medical Marijuana, I fully accept responsibility and assume the risks and side effects associated with its use. Dr. Harris informed me of the risks, complications, and expected benefits of treatment pertaining to my qualifying medical condition and medical history, including its likelihood of success and failure. _____initial

4. I agree that Bucyrus Internal Medicine, Inc., and employees shall not be held responsible or liable for any harm resulting to me and/or any other individual(s) because of my use of Medical Marijuana. _____initial

5. I certify that I have read this document and declare under penalties of perjury that the information contained herein is true, correct, and complete. I have initialed next to each to acknowledge this understanding. All Forms completed by me concerning my visit(s) are accurate and truthful. _____initial

Patient's (or legal guardian's) Signature_____ Date: _____

Printed Name:_____

Physician Signature: _____Date _____/____/____