Patient name as it appears on picture ID (must match):

(name) ____

Date of birth:

____

Mailing address:

____

Phone number: ____________________ Email: ____________________

Qualifying condition: ______________________________________

Medications:

____

____

____

Current physician: ______________________________________

Allergic to any medications? ______________________________

Smoke tobacco: Y or N if yes, how long and how much ____________________

Alcohol use: ______________________________________

Marijuana use: Y or N, if yes how long and how much ____________________

Any major surgeries or hospitalizations: ____________________

____

Anything you want us to know? ______________________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: ______________

Witness: ____ Date: ______________

Patient Consent and Agreement:

I have received a copy of the CT HIPPA form and accept those practices.

I hereby declare that I have truthfully and completely disclosed all information regarding my medical and behavioral health conditions.

I consent to an evaluation by the practitioner for certification for the medical use of cannabis.

I agree to provide documents pertaining to my medical condition if requested.

Patient Name (print) ______________________________

Patient Signature ______________________________

Witness Initials ______________________________

Date: ______________________________

Informed Consent: Risks and Side Effects, Release of Liability

Name: ____ **Date:** ____________

Date of Birth: ____________

Please read each item below and initial in the space provided to indicate that you understand the information regarding the risks and side effects of using cannabis. I agree to tell the attending physician if I do not understand any of the information provided.

- I understand that the cultivation, possession and use of cannabis, even for medical purposes, are currently illegal under **federal** law. ________
- I understand that cannabis is not regulated by the U.S. Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and or contaminants. _______
- I understand that the attending physician, including the physician's employees, may not provide information regarding where medicinal cannabis might be obtained. Doing so would be a violation of **federal** law. ______
- The efficacy and potency of cannabis varies widely depending on the cannabis strain and ingestion method. Under federal law, the attending physician is unable to discuss dosage. ________
- Symptoms of a cannabis overdose include, but are not limited to, nausea, vomiting, numbness, irregular heartbeat, drowsiness, and anxiety. ________
- In the event of an overdose, I am advised to lie down, relax, and rest. If the symptoms persist, I agree to contact the attending physician or call 911 if needed. ________
- Cannabis smoke contains tars and may include carcinogens (chemicals that can cause cancer) that have potentially harmful effects including increasing the risk of respiratory diseases and cancer of the lungs, mouth and tongue. _______
- There is little known regarding how cannabis may, or may not, react with other pharmaceutical or herbal medications. _________
- Use of cannabis may result in higher and higher dosages due to user's development of a tolerance to cannabis. ________

- I understand that the use of cannabis may affect my coordination and cognition. I agree not to operate heavy machinery, drive or engage in potentially hazardous activities while using cannabis.________

- I understand that it is against the law to drive a vehicle while using marijuana and that I can get a DUI for driving under the influence. ________

- The use of a vaporizer, as an ingestion method, can substantially reduce the potentially harmful effects of smoking cannabis. ________

- Cannabis may be ingested in a tincture or edible form that eliminates some of the potentially harmful effects of smoking. ________

- I understand that any of the following side effects can result from the use of cannabis: ___________

  - Short term memory loss
  - Low blood pressure
  - Anxiety/Nervousness
  - Sedation
  - Irregular heart beat
  - Difficulty completing complex tasks
  - Dry mouth
  - Inability to concentrate
  - Slower reaction time
  - Paranoia, psychotic symptoms (delusions)
  - Suppression of immune system
  - Poor physical coordination
  - Talkativeness
  - Hunger
  - Impairment of motor skills
  - Loss of appetite reaction time, coordination
  - Dizziness
  - Cough
  - Dependency
  - Confusion
  - Impaired vision
  - Feeling of euphoria
  - Drowsiness
  - Headache
  - Nausea/Vomiting
  - Fatigue
  - Apathy
  - Depression
  - Changes in sleep patterns
  - Numbness
  - Laryngitis
  - Bronchitis
  - Shortness of breath
  - Agitation/irritability
  - Trouble concentrating

- I understand that there may be benefits and risks associated with the use that have not been identified. ________

- I agree to stop using cannabis and inform the attending physician in the event that I experience depression, have thoughts of suicide, or any other mental problems. _______

- I also agree to inform the attending physician of any anti-psychotic medication that I may be taking currently or in the future. _______

- There is a possibility that cannabis may worsen schizophrenia in persons predisposed to that disorder. __________

- I agree to stop using cannabis and inform the attending physician if I am experiencing any negative side effects that may be caused from my therapeutic use of cannabis. _________

- There is the possibility of experiencing withdrawal symptoms when I stop using cannabis. I understand that these withdrawal symptoms can include, but are not limited to, depression, irritability, insomnia, loss of appetite, and tiredness. _______

- I understand that cannabis is not recommended while under the influence of alcohol. _______

- I hereby state that I fully understand the potential risks and side effects related to the use of cannabis as described above. ________

- Furthermore, in using cannabis therapeutically, I accept full responsibility in assuming the risks and side effects related to its use. ________

- I agree that the attending physician and his/her principals, agents, and employees, shall not be held responsible for any harm resulting to me and/or other individuals as a result of my medicinal use of cannabis. __________

Patient Signature:____ **Date:**____________________

Physician Reviewed:____ **Date:**____________________

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, growing or distributing medical marijuana.

I attest that I am not a member, employee 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 devise 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 any medical records to the physician. I also hereby authorize MarijuanaDoctors.com or it's representative, to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician 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 or failure.

I acknowledge the attending physician 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 condition. I will be informed of all the above-mentioned regardless of whether or not I qualify as a patient.

Patient Name (Print) ______________________ **Telephone#** ______________________

Patient Signature ______________________ **Alt. Phone#** ______________________

Current Address

____

City ______________________ **State** ______________ **Zip** ______________