PATIENT INTAKE PACKET

Welcome to the **CannaMD** family - you're in great hands! To reduce your visit and wait time, we ask that you please complete and submit this intake packet at least 24 hours prior to your scheduled appointment. During your visit, we are required to verify your identity; please **bring your Florida driver's license** or state-issued identification card so our staff can make a copy.

Included forms are listed below

- Consent to Treatment (1 page)
- Patient Intake Questionnaire (2 pages)
- Notice of Privacy Practices (4 pages)

Please note: All dark blue fields are required. Light blue fields are optional. Text next to the form's title (top, center) will track how many required fields are left.

MEDICAL RECORDS

Florida state law requires that we see supporting documentation or a doctor's note confirming your diagnosis for a qualifying condition. We do **not** need to see lab results, x-rays, or other medical charts. Please provide our staff with this documentation *before* your scheduled appointment so we can verify eligibility prior to your visit.

You may submit files via several methods:

- **Patient portal:** Upload paperwork to your patient portal at http://patients.florpass.com. (You should have received an email to create an account when you scheduled your appointment.)
- **Email:** forms@cannamd.com
- **Fax:** 1 (800) 877-1589

CANCELLATION POLICY

We understand that, at times, you simply can't make an appointment due to emergencies or other unforeseen obligations. In this event, we ask that you please call us to reschedule; reserving an unnecessary appointment time may prevent other patients from getting the treatment they need.

It is our policy that all appointments must be rescheduled at least 48 hours in advance. If you fail to reschedule your appointment 48 hours in advance, you will be charged a $50 rescheduling fee to secure another appointment time.

REFUND POLICY

All refund requests must occur within 90 days of initial payment. Refunds will not be issued after this point.

Telehealth patients acknowledge that electronic signatures may be required and that signing electronic forms may be a required part of the certification process. While CannaMD will make every attempt to assist, inability and/or failure to sign electronic forms will not constitute grounds for a refund.

CannaMD

CONSENT TO TREATMENT

I hereby authorize CannaMD, its physicians, and staff (hereby referred to as the "Practice") to examine and evaluate my medical condition(s). Based on its findings, the Practice will:

- Determine whether I qualify to be certified for the use of low-THC and/or medical cannabis per state regulations, place my order for low-THC and/or medical cannabis if I do qualify, and add, access, and update my record in the Medical Marijuana Use Registry.
- Examine and evaluate me for treatment going forward. (I understand I may be expected to provide urine for testing by a licensed clinical laboratory or by the Practice. I hereby authorize the Practice to collect and submit specimens for required testing and access results on my behalf.)
- Explain available remedies and treatments indicated by the results of my examination.
- Outline the significant risks and dangers associated with each remedy and treatment including, but not limited to, the potential benefits and risks of using low-THC cannabis and/or medical cannabis.
- Explain alternative medical solutions to each remedy and treatment, if acceptable alternatives exist.

As a patient of the Practice, I further acknowledge that:

- There is very limited scientific data available regarding the potential danger(s) of long-term low-THC cannabis and medical cannabis use.
- There are no guarantees regarding the benefits I may or may not experience from using low-THC cannabis and/or medical cannabis.
- The possession and use of low-THC cannabis and/or medical cannabis violates federal law.

I have read this *Consent to Treatment* and understand I will have the opportunity to have all of my questions answered by the Practice with respect to the treatments and therapies referred to above. I fully understand and acknowledge receipt of this form; I am signing it voluntarily.

Print Name: _____

Signature: _____ Date: _____

CannaMD

PATIENT INTAKE QUESTIONNAIRE

Full Legal Name: _____

SSN: _____ Phone: _____ DOB: _____

Address: _____

Medical Indications

Choose/List the conditions for which you are seeking medical cannabis treatment **and have supporting documentation:**

- ☐ ALS (Lou Gehrig's)
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ HIV/AIDS
- ☐ Multiple Sclerosis (MS)
- ☐ Parkinson's Disease
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Terminal Condition
- ☐ Chronic Nonmalignant Pain

Other: _____

Caregiver Information

If applicable:

Caregiver Name: _____

Caregiver Phone: _____

Caregiver Registry ID: _____

Social & Habitual Status

Marital status: (pick one)

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Common Law
- ☐ Domestic Partnership
- ☐ In a Relationship

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Are you a veteran or active duty military? ☐ Yes ☐ No

Occupation: _____

Tobacco Use? ☐ Yes ☐ No If Yes, what type and how often? _____

Alcohol Use? ☐ Yes ☐ No If Yes, how often? _____

CannaMD

Current/Past Medical History & Medications

List ALL allergies:

List ALL current medications (including dose and frequency):

List ALL current and past medical history (including diagnoses, surgeries, and hospitalizations):

Do you or your immediate family have a history of the following diagnoses (check all that apply):

- ☐ Heart Disease
- ☐ Bipolar
- ☐ Depression
- ☐ Substance Use Disorder
- ☐ Stroke
- ☐ Schizophrenia
- ☐ PTSD
- ☐ Liver Disease
- ☐ Psychosis
- ☐ Anxiety

History of Opioid & Cannabis Use

Are you currently prescribed opioids or methadone/Suboxone? ☐ Yes ☐ No

Are you currently using cannabis? ☐ Yes ☐ No

If yes, outline in detail your daily cannabis routine:

Do you currently have a medical card for cannabis? ☐ Yes ☐ No

If yes, who is your treating physician? _____

List ALL other medications/treatments that you have attempted before considering cannabis and why you chose to stop those treatments:

How does cannabis help your condition?

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

I acknowledge that I have read and/or received a copy of this Notice of Privacy Practices

Print Name: _____

Signature: _____ Date: _____