MARIJUANA DOCTOR

How did you hear about us?
☐Returning Patient ☐Drive-by ☐ Google ☐ Craigslist ☐ New Times
☐Other: _____

Patient Information (please print your **legal** name legibly) Pronouns/Preferred Name:

First Name: _____ **Last Name:** _____

Date of Birth: (MM/DD/YYYY) _____ **Gender:** ☐Male ☐Female

Phone #: _____ Email: _____

Is this your first Medical Marijuana Card? ☐Yes ☐No
If No, then has your previous card already expired? ☐Yes ☐No
If it has not expired, then please provide your Medical Marijuana Patient Card Number?

_____

Residential Address

Address: _____

Zip Code: _____City: _____ County: _____

Mailing Address (only fill this out if it is different than your residential address)

Address: _____

Zip Code: _____City: _____ County: _____

Is your residential and mailing address the same? ☐Yes ☐No

Are you requesting a Caregiver? ☐Yes ☐No
If yes, what is your caregiver's name and phone number?

_____

Are you requesting Growing Rights? ☐Yes ☐No (if you wish to cultivate marijuana, you must live at least 25 miles away from a dispensary and have a clean criminal record. Please ask for details).

Do you Receive Food Stamps? ☐Yes ☐No (proof is required by AZDHS)

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We process your application as a courtesy. You do have the option to process your own application online. If we make a clerical error that extends the amount of time that it takes for you to receive your card in the mail, we are NOT liable to provide you with any refund

Payment Method

☐ Visa ☐ Mastercard ☐ Cash

If you provide a Visa or Mastercard number, then our patient coordinator can utilize your card to pay the $150 (or $75 with proof of EBT) AZDHS fee. This enables us to upload your packet faster because you pay the government directly verses having the money go through us. We redact your entire card number immediately after use.

If you choose not to provide a Visa or MasterCard number below, you may pay cash for the state fee, or pay a $10 surcharge for credit card processing fees. Discover and AmEx are not accepted by the state, and are subject to the surcharge as well. We apologize about any inconvenience.

Card Number: _____
Expiration: _____/_____ CSV#: _____

Billing address (if it is different from the Residential)
Address: _____
Zip Code: _____City: _____ County: _____

**You must have sufficient funds in your account before processing payment for the Arizona Department of Health Services in the amount of $150 ($75 if you receive food stamps). Any changes in the above information will result in a $30 change fee. I am aware that there are numerous legal challenges to the Arizona Medical Marijuana Act (AMMA). If the AMMA were ever to be overturned, there are no refunds for this application fee. (AZDHS.GOV) **

I agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

_____ _____
Patient Signature **Date**

_____
Print Name

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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.

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Patient Name: _____

Patient Signature: _____ Date: _____

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Please ask your patient coordinator if you would like an easier to read version of this information.

I hereby authorize Precision Medical Group to disclose, release and verify my records as a patient to a marijuana dispensary, caregiver or coop for the purpose of obtaining marijuana. I understand that this authorization is valid for the period of time for which the recommendation for marijuana has been issued by my Precision Medical Group physician.

I hereby authorize the use and disclosure of my Precision Medical Group patient records, except for personal identifying information, for use in data analysis of cannabis treated patients.

I hereby authorize Precision Medical Group to disclose and verify my medical records to law enforcement should I be arrested or detained related to my possession or use of marijuana. I understand that Precision Medical Group will only provide verification of my patient status for the purpose of providing proof to justify my possession of marijuana. I understand that this authorization is valid for the period of time for which the recommendation for marijuana has been issued by my Precision Medical Group physician.

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 have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or nonmedical 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 marijuana.

I must be an Arizona resident and over the 18 years of age to obtain an approval or recommendation for the use of cannabis (medical marijuana) under Arizona law. If I am under 18 years of age I must have a parental consent and authorization for the use of medical marijuana.

The federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 Substance are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Arizona, which have modified their state laws to treat marijuana as a medicine.

Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and /or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.
I agree to contact Precision Medical Group if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Precision Medical Group if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician.

The risks, benefits and drug interactions of marijuana are not fully understood, If I am taking medications or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

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_____ _____

Patient Signature **Date**

_____

Print Name

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Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Precision Medical Group.

Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to the nearest emergency room.

If Precision Medical Group subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with Precision Medical Group and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

I acknowledge the Precision Medical Group Physician informed me of the nature of a recommended treatment, including but not limited to, recommendations regarding medical marijuana. The Precision Medical Group physician also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the Precision Medical Group physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

Furthermore, I, the undersigned (including my heirs, or anyone action on my behalf), hold Precision Medical Group, the physician and his/her principals, agents, employees and management, harmless and release them from any liability resulting in any way whatsoever from my use of marijuana. This release of liability includes, but is not limited to, any bodily or psychological injury, whether know or unknown, as well as legal and /or employment problems resulting from my use of marijuana.

The attending physician, staff and or representatives of Precision Medical Group are neither providing, dispensing nor encouraging me to obtain medical marijuana.

The attending physician, staff and or representatives of Precision Medical Group will NOT be providing of discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

The physician, staff and representatives of Precision Medical Group are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the physician. It is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

I acknowledge that I am a resident of Arizona, I am at least 18 years of age and have not misrepresented any information to Precision Medical Group.

I acknowledge that I am not an agent of law enforcement, state of federal government here for the purpose of investigation or entrapment.

I acknowledge that I am not recording any portion my visit with Precision Medical Group nor do I possess any recording equipment. I understand Precision Medical Group does not approve of such action. I further acknowledge that, without express written permission of Precision Medical Group, it is illegal to film or record in this office with video camera, cell phone or any other recording devices, including still image, video or audio. Any such action is a direct violation of HIPAA regulations and patient/doctor confidentiality.

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Patient Signature **Date**

Print Name

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Personal Information:

Name**:** _____ DOB**:** _____

Age: _____ Height**:** _____ Weight**:** _____ Gender: _____

Please check mark ✓ what medical marijuana qualifying condition(s) you suffer from:

☐ **Chronic Pain (no records required)**

☐ Cancer	☐ Alzheimer's	☐ Seizures
☐ Muscle Spasms	☐ ALS	☐ Crohn's Disease
☐ Nausea	☐ Glaucoma	☐ HIV / AIDS
☐ PTSD	☐ Hepatitis C	☐ Cachexia

****Medical Records Are Required to qualify with any condition other than Chronic Pain****

Please give a brief description of the condition you checked above:

_____
_____
_____

Medications (any taken within the last year)**:** _____
_____
_____
_____

Allergies (to medications)**:** _____
_____

Surgical History Relative to Your Chief Complaint (include approximate dates):

_____
_____
_____

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Other treatments:

☐ Physical Therapy ☐ Surgery ☐ Chiropractic ☐ Massage
☐ Herbal Therapy ☐ Counseling ☐ Exercise ☐ Acupuncture
☐ Topicals ☐ Over the Counter Meds ☐ Prescription Meds
☐ Ice / Heat
☐ Other(s)_____
_____

Do you have, or have you ever had any of the following medical problems?

☐ Asthma/Lung Disease ☐ Cancer
☐ HIV/AIDS ☐ Diabetes
☐ Epilepsy/Seizures ☐ Multiple Sclerosis
☐ Liver Disease ☐ Intestinal Disorders (IBS, Ulcers)
☐ Kidney Disease ☐ High Blood Pressure
☐ Heart Disease ☐ Psychiatric Disorders (depression, anxiety)

Drug and alcohol History, do you currently use:

☐ Tobacco Number of cigarettes per day _____
☐ Alcohol Number of drinks per week _____

Female Patients Only:

Are you pregnant? ☐Yes ☐No
Are you currently breastfeeding? ☐Yes ☐No

Please Provide any additional information that could be relevant to the physician's evaluation: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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What medications have you reduced or eliminated with marijuana?

_____
_____
_____

How often do you you use marijuana?_____
☐ Every day or nearly every day
☐ Approximately 1-2 times per week
☐ More than once a month
☐ Never

What is your preferred method of using marijuana?
☐ smoke
☐ vaporizer (concentrates)
☐ ingested (edibles)
☐ topical (creams)
☐ I do not know

How effective is marijuana for your medical problem?
☐ Very effective
☐ Effective
☐ Only somewhat effective

Do you have an open court case regarding marijuana?
☐ Yes
☐ No

Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skill, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in a person predisposed to this disorder. In addition, the use of marijuana may increase eating, alter my perception of time and space and may impair my judgment.

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I, _____, understand the potential side effects of Medical Marijuana use.

_____ _____
Signature Date Signed

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

MARIJUANA PROGRAM PATIENT ATTESTATION

I, _____ , attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed