PATIENT INTAKE FORM

Date: _____ MMCC ID #: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Indication(s) for Cannabis Treatment Chief complaints/symptoms:

_____

_____

_____

MEDICAL HISTORY

Ongoing medical problems, including asthma, COPD, diabetes, heart disease, heart murmur, hepatitis, HIV/AIDS, hypertension, kidney failure, venereal disease, alcohol and/or drug addictions, any present or past psychiatric care.

_____

_____

_____

Allergies – Name drug & reaction, including any type of anesthetic:

_____

Prescriptions and over-the-counter medications, name and dosage, including Coumadin, Plavix, Persantine, or blood thinners.

_____

_____

_____

How did you hear about us? (circle one)

- Signs
- Google
- Weedmaps
- Trailer
- Postcard
- Website
- Facebook
- Instagram Other: _____

MEDICAL CANNABIS 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 cannabis recommendation for illegally obtaining, growing, or distributing medical cannabis.

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 still, image, video or audio. This is a direct violation of HIPPAA 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 cannabis. As well as 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 recommended treatment including the alternative of no treatment, and their risks and/or benefits. The physician has the right to request that I visit another physician or specialist to substantiate my condition. I will be informed of all mentioned above regardless whether I qualify as a medical cannabis patient.

Patient Name: _____ Telephone: _____

Patient Signature: _____Alt Phone: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

The Health Center, LLC
3460 Old Washington Rd, Suite 101A
Waldorf, MD 20602
301-262-2168

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected information protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restriction on certain uses and disclosures protected health information, and that this practice is not required to agree to a requested restriction
  - The right to receive confidential communications of protected health information
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy practice at my request.

Signature: _____ Date: _____