Patient In-Take

Medical Intake Date:__________________

Name:____

Delegate (If Applicable): ______________________________

Gender: ☐ Male ☐ Female ☐ Other

Date of Birth:___________________________________

Address:______________________________________

City:____

Zip Code:______________________________________

Home Phone:___________________________________

Cell Phone: ___________________________________

Email:____

Permission to contact Primary Care Physician?

☐ Yes ☐ No

Physician Name:________________________________

Permission to contact Dispensary?

☐ Yes ☐ No

Dispensary Location:____________________________

LIST EMERGENCY CONTACT

Contact:______________________________________

Phone Number: ________________________________

Relationship:___________________________________

List ALL Debilitating Conditions for which you are seeking Medical Marijuana Treatment:

____

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How did you Hear about us?

☐ **Friends** ☐ **Physician**

☐ **Family** ☐ **Billboard**

☐ **Radio**

☐ **Search Engine:**_________________________

☐ **Social Media:**__________________________

Demographic Information

☐ Caucasian (White)

☐ African American (Black)

☐ American Indian / Alaskan Native

☐ Asian / Pacific Islander

☐ Hispanic origin

☐ Not Hispanic origin

Marital Status

☐ Currently Married ☐ Single

☐ Widowed ☐ Divorced

☐ Separated ☐ Domestic Partnership

Employment

☐ Full-time ☐ Part-time

☐ Retired ☐ Self-Employed

☐ Student ☐ Homemaker

☐ Disabled

Safety Sensitive Job ☐ Yes ☐ No

*Cannabis is **NOT RECOMMENDED** for use when employed in safety sensitive positions.*

Patient Initials: ________________

Patient In-Take

Are you currently serving active duty in the U.S. Armed Forces, Military Reserves, or National Guard?

☐ Yes

☐ No

*Cannabis in ANY form, is **NOT allowed** on any active U.S. Military base by either active duty/retired military or their families.

*Furthermore, cannabis in ANY form has **NOT** been approved for use by any **ACTIVE DUTY** Military personnel.*

Medical History

Hospitalizations:______________________________

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____

Surgeries:______________________________

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Hereditary Diseases: ______________________________

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Social History

Significant Traumatic Events:____________________

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Current Mental Health/Psychiatric Issues:__________

____

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____

If you are currently experiencing severe psychiatric complications, please seek assistance, we have contact information for resources available to you if you need them.

Current Marijuana Use:
(Please be honest, all information is CONFIDENTIAL):

____

____

____

____

Patient Initials: ________________

Ongoing Medical Problems

☐ Asthma ☐ COPD
☐ Diabetes ☐ Heart Disease
☐ Heart Murmur ☐ Hepatitis
☐ HIV/AIDS ☐ Hypertension
☐ Kidney Failure ☐ Psychiatric
☐ Care Venereal Disease
☐ Alcohol/Drug

Additional:______________________________________

____

Allergies:______________________________________

Clinical history of diagnosed qualifying condition(s) and primary reason(s) to seek medical marijuana treatment

Primary complaints:______________________________

____

____

____

____

Symptoms:______________________________________

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Frequency:______________________________________

____

____

Severity:______________________________________

____

____

Prior Treatment:______________________________

____

____

Duration:______________________________________

____

Outcome: (Failure or success):__________________

____

List all medications
(Including all Herbs and OTC Medication)

____

____

____

____

____

____

____

Does patient take any of the following:

☐ Aspirin ☐ Coumadin ☐ Blood Thinners
☐ Plavix ☐ Persantine

Preventative Care

Treatments:______________________________________

____

Special Diets:____________________________________

____

Physical Therapy:_________________________________

____

Patient Initials: ____________________

If patient is **FEMALE**: are you currently or planning to become pregnant?

☐ Yes ☐ No ☐ Maybe

Breast Feeding?

☐ Yes ☐ No

Menstruation?

☐ Yes ☐ No

Date of Last Cycle: ______________________________

*This Section is **N/A** to me ☐

Nutritional History

Special Dietary Needs/Food Allergies:

____

____

____

Please inform your Dispensary technician and/or pharmacist if you have specific allergies.

Office Policies

The Healing Clinic, LLC and staff provide you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and practice.

Self-paying patients

Payments for services are due before services are rendered. Any outstanding balance must be paid in full before recommendation can be released to a dispensary in the State of Louisiana. I have read and fully understand the policies of this clinic regarding payments and I agree to pay for all services and tests rendered at the time of this visit.

*****NO REFUNDS PERMITTED: EXCEPTION BY SPECIFIC CIRCUMSTANCES APPROVED BY STAFF*****

Informed Consent

I understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions.

I have been advised that the use of medical marijuana may affect my coordination, motor skills, and cognition in ways that could impair my ability to drive and agree **NOT** to **operate heavy machinery, drive, or engage in potentially hazardous activities.**

I understand that adverse effects may occur while I am taking medical marijuana. Adverse effects of medical marijuana may include but are not limited to: euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia, and increased eating.

I understand that some patients may become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms may include feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

I understand it can be classified as a **felony** to be in possession of marijuana while armed **with a firearm**.

I understand that although marijuana does not produce a specific psychosis, it may exacerbate schizophrenia in persons predisposed to that disorder.

I agree to tell my attending physician if I have ever had symptoms of depressions, been psychotic, attempted suicide, or had any other mental problems. I also agree to tell my attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that my attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical conditions.

FURTHERMORE, I UNDERSTAND that my attending physician **DOES NOT** treat any mental health issues and that I must seek treatment elsewhere for any Mental Health conditions I am experiencing.

Patient Initials: ____________________

I understand there are few known interactions between marijuana and medications other than herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements, or other medications.

I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of marijuana as a medicinal drug. I understand the significance of this fact.

I am aware that medical marijuana has not been approved under the Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug periodically or as recommended by my physician. If I think I may be developing a tolerance to marijuana, I will notify my attending physician.

I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

I understand that if respiratory problems or other ill effects experienced in association with the use of medical marijuana appear, I agree to discontinue its use and **report any such problems or effects to my attending primary care physician.**

I understand marijuana varies in potency. The effects of marijuana may also vary with the delivery method. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, heart rhythm disturbances, numbness in the limbs, anxiety attacks, and incapacitation.

If I start taking medical marijuana, I agree to tell my attending physician if I start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking and out of your normal behavior.

I agree that if I am a female patient that I will contact my attending physician if I become or am thinking about becoming pregnant. I acknowledge that the use of medical marijuana potentially creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

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 understand that I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities, and or contaminants.

I am not permitted to use medical marijuana within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home. ***Cannabis, In ANY form, is NOT allowed on any active U.S. Military base by either active duty military or their families.***

I agree to follow up with my attending physician at The Healing Clinics, LLC with supporting medical records pertaining to my medical conditions.

I understand my attending physician, staff, and/or representatives of The Healing Clinics, LLC are neither providing or dispensing medical marijuana. I also acknowledge that my attending physician, staff, and/or representatives will NOT be providing or discussing information regarding for any alternative means to obtain marijuana.

I certify that I have read this document and declare under penalty of perjury that the information contained herein is true, correct, and complete. I acknowledge that any manipulation, alteration, or falsification of this form, the letter of recommendation will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, the above-mentioned activities will be reported to the appropriate local authorities.

Patient Initials: ________________

The physicians, staff, and representatives of The Healing Clinics, LLC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician or provider. Furthermore, the undersigned, my heirs, assignees, or anyone else acting on behalf, hold the physicians and his/her principals, agents, and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

Treatment Goals

I understand that the main treatment goal is to improve the quality of my life. This includes the ability to function and/or work. In consideration of this goal, and because I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. I must also comply with the treatment plan as recommended by my physician. I understand that a successful outcome to my treatment may be enhanced by following a healthy lifestyle.

Patient Responsibility

Patient understands and voluntarily agree that:

- ✓ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.
- ✓ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be terminated.
- ✓ I am responsible for the controlled substance medications recommended to me. If my medication is lost, misplaced, or stolen, I understand that I will have to consult with my physician in regards to it being replaced with no guarantee that it will be replaced.
- ✓ I will use the medication as my doctor recommends.
- ✓ I will keep my doctor informed of all my medications (including herb and vitamins) and medical problems.
- ✓ I understand that operating a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State of Louisiana and/or the State in which I am traveling in/to while taking the recommended medications.
- ✓ I will keep my physician informed of the medications/diagnoses from any other physician or individual without first informing my Therapeutic Marijuana Physician while I am receiving such medications from this clinic. I will not give, share, or sell my medications to any other person.
- ✓ I understand that I must maintain a primary care physician while being cared for in this clinic, the aforementioned physician will be used to care for my other medical needs, and that we may coordinate care with your physician.
- ✓ As part of our Diversion Control Program, patients may be asked to bring medication to the clinic for dispensed product counts and/or given urine drug screenings.
- ✓ It is my responsibility to inform my primary care physician and/or Pain Management Physician of my enrollment at The Healing Clinics, LLC and that my physician here at The Healing Clinics, LLC may coordinate care with that physician as necessary to my treatment here at The Healing Clinics, LLC.
- ✓ In case of emergency, I will call 9-1-1

Refills of Medications

Refills will be made only during regular office hours Monday through Friday. Refills will not be made after hours, on weekends, or on holidays.

Risks of the Therapeutic Use of Marijuana

I understand that there are potential risks involved with both the therapeutic use of marijuana and alternative conventional treatment options. Caution should be taken against driving, operating machinery, or performing any task that requires the patient to be alert or react when under the influence of the drug.
Medication must be stored in a secured location to reduce the risk of exposure to children or diversion by others. Therapeutic marijuana has not yet been approved by the USFDA for the treatment of debilitating medical conditions and possession may be viewed as illegal under federal law, and subject to federal (and workplace) enforcement action.

Release of Liability

I attest that the information on this form is correct and

Patient Initials: ________________

any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize The Healing Clinics, LLC to converse internally of my medical condition.

I affirm that I have a debilitating medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement to my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration. Furthermore, I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to my cardiovascular and pulmonary systems, psychomotor performance, and risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

Medical Marijuana 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, IF SO, I must disclose that the intent of my participation is not medical in nature. It is illegal to film or record in this office with a video camera, cell phone, or any other recording device 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 my medical records to the physician.

Additionally, I acknowledge my 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, including possibly making an acute or treatable progressive condition or that such will lead to a worsening of the patient's condition.

I acknowledge my 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.

Termination of Care

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice. I am responsible for any withdrawal syndrome that may occur due to my misuse of the narcotic medications and/or termination of my care.

Potential Drug Interactions Release

I understand that anticoagulants, anti-platelet drugs (including aspirin), herbs and supplements may reduce blood clotting. Cannabis may change how the body metabolizes these drugs and supplements, possibly increase the risk of bleeding. I also acknowledge that mixing cannabis with selective serotonin reuptake inhibitors, or other anti-depressants/anti-psychotics may increase the risk of mania or psychotic features.

Please consult directly with your specialist to monitor drug effectiveness and potential side-effects closely.

Patient Initials: ________________

I have read and understand the information provided regarding Potential Drug Interactions with Cannabis, have discussed it with my physician/healthcare provider, and have had all questions answered to my satisfaction.

Acknowledgement of Privacy Notice

I have been informed of the practice's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at or controlled by this practice. I understand I can obtain this practice's Notice of Privacy on request.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

By initialing this page, I hereby acknowledge that I have read and understand the privacy practice notice and may obtain additional copies upon my request.

Patient Acknowledgement and Agreement

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and representatives are addressing specific aspects of my medical care and are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the terms of the approval.

Patient Manner of Contact

I understand that this practice calls, texts, and emails to confirm appointments at the number and email address I provide.

****I, the patient, would like to be contacted**

☐ Restricted Method of Contact

List:____________________________________

☐ Text / Email (Circle One)

☐ No Restrictions

In general, the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. If I have any restrictions, I will list them below:

____

IT HAS BEEN MADE CLEAR THAT THE PHYSICIANS, STAFF, AND REPRESENTATIVES OF THIS CLINIC ARE NOT PROVIDING MEDICAL MARIJUANA, NOR ARE THEY ENCOURAGING ANY ILLEGAL ACTIVITY IN MY OBTAINING MEDICAL MARIJUANA

I HAVE READ THIS CONTRACT AND IN-TAKE FORM COMPLETELY, AS INDICATED BY MY INITIALS ON EACH PAGE (1-8), AND THE SAME HAS BEEN EXPLAINED TO ME BY MY PROVIDER AND THE HEALING CLINICS, LLC STAFF. ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I AGREE TO COMPLY FULLY WITH THIS CONTRACT. IN ADDITION, I FULLY ACCEPT THE CONSEQUENCES OF VIOLATING THIS AGREEMENT.

Traveling with Medicinal Marijuana

I understand that I am to consult TSA rules or an Attorney in regards to airway travel with medicinal marijuana. I understand that I am to consult with a cruise line consultant or an Attorney in regards to ocean/waterway travel with medicinal marijuana. I also understand that it is ILLEGAL to transport medical marijuana that has been recommended for me in Louisiana, across the state lines of Louisiana.

Signature:____________________________________

Date:______________________________________

Witness:_____________________________________

Revised 06.05.2020

Patient Consent for Telemedicine

The Healing Clinics, LLC offers telemedicine as a means of contact between the patient and their medical doctor using technology. This Telemedicine application begins with the consent of the Patient.

I, (Patient Name) ___________________________________ consent to Telemedicine as facilitated by The Healing Clinics, LLC.

1. I understand that I may choose to decline telemedicine facilitated medical services at any time and may withdraw from telemedicine care at any time. To decline or cancel the use of telemedicine, I will call 318-227-4088 and inform The Healing Clinics, LLC staff that would like to decline telemedicine or cancel my use of telemedicine if I am currently enrolled in the program.
2. If you choose to withdraw your consent for telemedicine, it will not affect your right to future care, treatment, benefits, or programs for which you are otherwise entitled. Alternative methods of care may be available.
3. I am aware that in using technology, any equipment failure may result in:
   - Delayed Care
   - Poor image and/or audio quality
   - Telemedicine Network and Software security protocols which protect confidentiality of your medical information could fail, causing personal information to be inappropriately revealed.
4. I understand that I must maintain a primary care physician while being cared for in this clinic and the aforementioned physician will be used to care for my other medical needs.
5. The Healing Clinics, LLC physician's role in patient care is to guide patients to a better quality of life with a treatment plan based on therapeutic marijuana. To do so, the clinic(s) will help in establishing the patients qualifying condition(s) through medical records supplied by their attending physician. Each physician must have a consultation with the patient either in person or by telemedicine to thoroughly understand the needs of each patient. No audio or video will be recorded from this consultation.
6. Your Telemedicine Physician is any physician on staff at The Healing Clinics, LLC as listed in your treatment plan. The Physician specialty is Therapeutic Marijuana for the purpose of this visit.
7. For follow-up appointments, copies of your medical records, or technical questions in case of equipment failure during the consultation, or to contact your physician please contact The Healing Clinics, LLC headquarters of Shreveport, LA at 318-227-4088 or info@thehealingclinics.com and The Healing Clinics, LLC staff will help assist you.
8. In case of an emergency, please dial 9-1-1 or have someone dial 9-1-1 for you if you are unable to do so.
9. Others may be physically present with you or with the remote specialist to operate equipment, or assist with evaluation, examination and/or treatment. Some parts of the exam involving physical tests may be conducted by individuals at your location at the direction of the telemedicine physician.
10. Telemedicine is intended to improve your access to specialized medical care by enabling you to be evaluated by a specialist at a remote or distant location. If you experience an emergency during the telemedicine visit, you understand that the remote specialist will arrange for follow up care through a local physician or healthcare provider. The remote specialist's responsibilities will then end upon the termination of the telemedicine connection.
11. Attached to this document package you will also find your Privacy Notice outlining your HIPAA rights.

I have read and understand the information provided regarding Telemedicine, have discussed it with my physician/healthcare provider, and have had all questions answered to my satisfaction.

Patient Signature:____ Date: ________________

Witness: ____ Date: ________________