The MARIJUANA DOCTOR at Precision Medical Group

Authorization for Release of Information

Please **initial** next to each entry to which you agree:

_____ I hereby authorize Precision Medical Group to disclose, release and verify my records as a patient to a marijuana dispensary,caregiver or co-op 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.

_____ _____

Patient Signature Date

_____

Print Name

The MARIJUANA DOCTOR at Precision Medical Group

Informed Consent And Release From Liability

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 non-medical 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 have been informed of and understand the following: [please **initial** each item]

1._____ 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.

2._____The federal government has classified marijuana as a Schedule1 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.

3._____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.

4._____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."

5._____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 person predisposed to that disorder. In addition, the use of marijuana may increase eating, alter my perception of time and space and impair my judgment.

6._____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.

7._____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.

8._____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.

9._____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).

10._____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.

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

12._____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.

13._____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.

14._____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.

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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.

_____ _____

Patient Signature Date

_____

Print Name

The
MARIJUANA
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at Precision Medical Group

Patient Acknowledgment

I understand that:
(**Initials**:)

_____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.

The MARIJUANA DOCTOR at Precision Medical Group

Health Questionnaire

Personal Information:

Date_____ Name_____ DOB_____ Age_____

Height:_____ Weight:_____ Gender: Male/Female

Medical History

Current medical complaint: (List the medical problem(s) for which you use or would like to use medical marijuana; include year of onset of symptoms)

_____
_____
_____
_____

Primary Care Provider: Please give the name & address of your health care provider (includes chiropractor/psychologist/acupuncturist etc.) Please also list the date you were last seen by that provider;

_____
_____
_____

Medications: List all of your medications (include prescription and over-the counter)

_____
_____
_____

List any medications that you are allergic to:_____
_____

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Other treatments: Check any other treatments you use for your condition

____Surgery ____physical therapy ____chiropractic ____massage ____herbal therapy
____counseling ____exercise ____acupuncture: _____other_____

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

____Asthma/Lung Disease
____HIV/AIDS
____Hepatitis
____Stroke
____Kidney Disease
____Heart Disease
____Substance Abuse
____Multiple Sclerosis
____ADD/ADHD
____Cancer
____Diabetes
____Epilepsy/Seizures
____Liver Disease
____High Blood Pressure
____Sleep Disorders (sleep apnea,insomnia)
____Intestinal Disorders (IBS,Ulcers)
____Psychiatric Disorders (depression,anxiety,etc.)

Female Patients Only:

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

Surgical History

Please list the surgeries that you have had (include dates):

_____

_____

_____

Drug and alcohol History

Do you currently use:

Tobacco Yes/No Number of cigarettes per day _____
Alcohol Yes/No Number of drinks per week_____

Marijuana History

Have you been evaluated by another physician (in any state) for medical marijuana? Yes / No
If yes, list the name of the practice,doctor,and date seen:

_____

_____

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Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for you medical condition? Yes/No

If yes, which medication have you reduced or eliminated and why ?

_____

_____

How often do you use marijuana?
( )everyday or almost every day ( )about 1-2 times per week ( ) more than once a month

What is your preferred method of using marijuana?
( ) smoke ( ) vaporizer ( ) ingested ( ) topical

How effective is marijuana for you medical problem?
( ) very effective ( ) effective ( ) only somewhat effective

How does marijuana improve the quality of you life?

_____

_____

Additional Information
Do you have an open court case regarding marijuana? Yes / No
Are you currently on probation? Yes / No

Please provide any additional information that may be relevant to the physician evaluation:

_____

_____

_____

_____

_____

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_____I acknowledge that it is up to me to become a patient of Precision Medical Group. If I decide not to be a patient after my evaluation, there will be no charge. In the event that I do pay and elect to be a patient of Precision Medical Group, there will be no refunds.

_____I acknowledge that marijuana, even if used for medical purposes,Is illegal under Federal law and has been placed on Schedule 1 by the US FDA. As such, marijuana is considered to have no medical benefit and a significant potential for abuse. I assume all responsibility for any violation of Federal law.

_____ _____
Patient Signature Date

_____
Print Name

_____

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today and,if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that I am not seeking marijuana for illegal purposes; I am not a reporter or member of the media working on a story;And i am not a member of law enforcement seeking to investigate or build a case against my physician or anyone affiliated with my physician.

_____ _____
Patient Signature Date

_____
Print Name

Print Form

ARIZONA DEPARTMENT OF HEALTH SERVICES

MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA 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

How did you hear about us? (Circle One)

Returning Patient *Drive-by* *Google* *Craigslist* *New Times*

*Friend/Family*_____ *Dispensary* _____
*Other Advertisements*_____

THE FOLLOWING INFORMATION IS NECESASARY FOR THE APPLICATION PROCESS

Patient Information

First Name _____Last Name_____
Suffix_____

Gender (Circle): Male or Female Date of Birth: _____/_____/_____

Phone: (_____) _____ - _____ Email: _____

Renewing your current Medical Marijuana Card? Card #_____

Residential Address

Address_____ UNIT/APT #_____

City_____ State_____ County _____ Zip_____

Mailing Address (IF DIFFERENT FROM ABOVE)

Address_____

Payment Information

Method (Circle): VISA MASTERCARD CASH

Card #: _____ Expiration _____/_____ CSV #_____

Billing Address (IF DIFFERENT FROM ABOVE)

Address_____

Caregiver (Circle): No / Yes - Name_____
Cultivate (Circle): No / Yes (excluding felonies/misdemeanors do NOT allow a patient to cultivate. All patients must live outside 25 miles from a dispensary per AZPROP 203)

Food Stamps Participant (Circle): **No / Yes**

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)

Print Name: _____ **Signature**_____
Date: _____/_____/_____