224 Mariner Boulevard
Spring Hill, FL 34609
352-686-9779 Phone
352-686-0727 Fax

Compassionate Cannabis Use

NEW PATIENT INTAKE PACKET

Thank you for your interest in our clinic. During your first visit, you'll be required to supply us with a valid Florida driver's license or state ID card. If you do not possess a valid Florida driver's license or Florida identification card, you may submit a copy of a utility bill in your name, including a Florida address, or a Florida voter registration card. For minor patients, the parent or designated legal representative must submit proof of residency of the parent or designated legal representative.

To streamline your initial appointment, we ask that you print, read, and complete each form within this packet prior to your scheduled visit.

The forms and paperwork included are:

- ***Qualifying Medical Conditions***
- ***Adult Personal Information Form***
- ***Adult Medical History Form***
- ***Appointments***
- ***Informed Consent***
- ***THC Patient Agreement***
- ***Release of Liability***
- ***Medical Release Form***
- ***Cancellation No/Show Policy***
- ***HIPPA Privacy Statement***
- ***Patient Reasons for THC***
- ***(PHQ) Health Questionnaire***

We would like to see your most current medical records for the last 12 months. You can ask your current primary care physician or specialist to fax or mail us a copy of your records. Our fax numberis 352-686-0727. You can print and complete our medical release form included within this packet andgive it to your current doctor.

If you are unable to complete or print this packet at home, you'll need to fill out all of this information at our office. Please arrive 30 minutes before your initial appointment to fill this out.

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Compassionate use of THC For Qualifying Medical Conditions

THC PROGRAM NOW BEING OFFERED BY DR. RUSSELL BAIN

GET YOUR COMPASSIONATE CARE CARD TODAY
SCHEDULE YOUR APPOINTMENT NOW! IT'S FAST, EASY AND 100% CONFIDENTIAL

Diagnosable conditions may be eligible for a THC recommendation, including: **Cancer, Epilepsy, Glaucoma, HIV/AIDS, PTSD, ALS, Crohn's Disease, Parkinson's Disease, Multiple Sclerosis**, **Anxiety, Cancer, Chronic Pain, Hepatitis C, Anorexia, Irritable Bowel Syndrome, Severe Nausea, Arthritis, Sickle Cell Anemia, Back Pain, Cachexia, Diabetes, Lyme Disease, Migraine, Spasticity, Cyclical Vomiting Syndrome, Muscle Spasms, Muscular Dystrophy or any Chronic Debilitating Disease.**

Florida Medical Marijuana Institute provides a stress-free, positive environment where patients in need of THC can receive a cost-effective, expert evaluation by Dr. Russell Bain who is certified in this field.

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APPOINTMENTS/COST

Set up an initial comprehensive appointment with Dr. Bain, where the decision will be made as to whether THC is the best treatment for the patient. If the decision is yes, Dr. Bain will then gather all patient information and he will decide the concentration, # of doses per day, and the best delivery device. Once this is done, he will enter all your information into the registry and fill out your application form. You need to get a passport picture and make a check out for $75.00 to the Florida Department of Health and mail it. Within 3 weeks you will receive a temporary card to take to the nearest dispensary.
Cost of the initial consultation is $299.00. (no insurance accepted)
You will then need to be seen approximately every 3 months for a re-evaluation. The cost for that appointment is $175. (we apologize, but no insurance company is covering this)

If you pay for the year upfront, a $100 discount will applied to the balance, making the total $600 for the entire year.

THC Acknowledgement of Disclosure and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree with the information regarding the risks and side effects of using THC. Do not sign this agreement and do not use THC if you have questions about or do not understand the information you have received. Please tell us if you do not understand any of the information provided.

Patient's Name: ____________________________Patient's Signature: _________________________

Address: ____

City: ___________________________ FL, Zip Code: _______________

Physician Obtaining Consent: Dr. Russell Bain

Physician Signature: ____ Date ____/_____/_____

WARNINGS:

I am being evaluated for a physician's order for THC. The physician will make this order, based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use THC 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 THC. I have been informed of and understand the following:

Please have Patient read and INITIAL *ALL* of the following boxes:

I understand that possession or use of THC is unlawful under Federal law and outside of the state of Florida. I also understand that possession or use of THC is unlawful within the state of Florida if not recommended for medical purposes by a licensed medical doctor with the legal ability to do so.	
Certain forms THC may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration and was produced without FDA oversight for health, safety, or efficacy. THC may contain unknown quantities of active ingredients, impurities, or contaminants.	

The efficacy and potency of THC may vary widely depending on the strain and ingestion method.	
If THC is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten, or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.	
There is limited information on the side effects of using THC, and there may be associated health risks.	
Symptoms of THC overdose include but are not limited to nausea, vomiting and disturbances to heart rhythm.	
For some patients, chronic THC usage can lead to laryngitis, bronchitis, and general apathy.	
I understand side effects of THC can include but are not limited to: Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, Poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation	
The scientific basis for the medical use of THC is not complete. There is little known regarding how THC may, or may not react with other pharmaceutical or herbal medications.	
Some patients can become dependent on THC. This means they experience withdrawal symptoms when they stop using it. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.	
Some users develop a tolerance to THC. This means higher and higher doses are required to achieve the	

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same symptom relief.	
The possibility exists that THC may exacerbate schizophrenia in persons predisposed to that disorder.	
Women should not consume THC while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice or the infant's pediatrician.	
Using THC while under the influence of alcohol is not recommended.	
The use of THC may affect coordination, cognition, and judgment. While under the influence of THC, do not to drive, operate machinery, or engage in potentially hazardous activities.	
Please note that THC will degrade over time. Always keep out of reach of children and pets.	

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THC Patient Agreement

I have never had symptoms of schizophrenia or have been diagnosed as having schizophrenia by a physician or mental health professional.	
I understand that my medical professional does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.	
I am not pregnant, intending on becoming pregnant, or breastfeeding.	
When under the influence and/or in possession of THC in public, your state issued THC ID Card or temporary state issued verification should be on your person at all times.	
I understand if I give dishonest or untruthful information, I will be discharged.	
I understand I must give **24 hours notice** for cancellation of appointments. I further understand that 2 or more no calls/no shows within a calendar year will result in my discharge from the practice as well as possible revocation of patient recommendation.	

I understand there are certain requirements to remain in compliance with Florida law regarding THC.
Some of these requirements include (but are not limited to):

- Regularly scheduled follow-ups at intervals determined by state law (every 3 mo.)

I understand that the Department of Health may revoke a Compassionate Use Registry identification card for any of the following:

(a) The patient or legal representative makes material misrepresentations in his or her application.
(b) The patient uses his or her card to obtain cannabis for another individual
(c) The legal representative purchases, obtains, possesses, or uses cannabis not sold by an approved
(d) dispensing organization, or
(e) The patient is no longer a qualified patient.

I understand and acknowledge that my patient information must be provided to the Office of Compassionate Use and that my treatment plan (and follow-up treatment plans) must be provided to the University of Florida'sCollege of Pharmacy by state law.

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Release of Liability

I hereby acknowledge **Florida Medical Marijuana Institute** and its employees are not addressing specific aspects of my medical care nor are any of them my primary care provider. Furthermore, I, for myself, my heirs, assigns, or its principals, agents, and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals because of my THC use.

I certify that I fully understand the potential risks and side effects related to the use of THC as described above.

In using THC, I fully accept responsibility and assume the risks and side effects associated with its use.

I agree that **Florida Medical Marijuana Institute**and employees shall not be held responsible for any harm resulting to me and/or other individual(s) because of my use of THC.

I certify that I have read this document and declare under penalties of perjury that the information contained herein is true, correct, and complete.

Patient Name:________________________________

Patient Signature:_____________________________

Florida Medical Marijuana Institute

Tel: 352-686-9779 Fax:352-686-0727

Release Form

I, ____(PRINT PATIENT NAME)
Date of Birth: ____/____/_____ SOCIAL SECURITY #: ___________________________
Authorize:____
(Doctor Name) (Doctors Phone or Fax Number)

to release and discuss any and all medical records and medical information that you have for me in your possession regarding my medical condition and my medical treatment, including but not limited to, my medical history, my medical treatment, your findings regarding my medical condition, records of consultations that I have had, records of medication prescribed for me, x-rays taken of me, my radiology reports and hospital, and medical records to;

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for the sole purpose of medical records review and certification of my medical condition.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is intended to be an unlimited, full, and complete Authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Medical Records Access Act, as amended, and under the rules and regulations thereof, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. A covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b) (4) applies. It is understood that the person towhom this Authorization is given has my permission to use and disseminate this information in his or her sole discretion.

1. **Expiration.** This authorization expires 18 months after patient signed this release.

2. **Right to Revoke**. I have the right to revoke this authorization by signing and dating a written statement revoking this authorization, and it shall become effective on delivery to you. If this authorization is revoked, any person or entity acting in good faith in reliance upon it and lacking actual knowledge of its revocation shall be held harmless.

3. **Redisclosure**. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this rule.

4. **Administrative Provisions**. I revoke any prior authorizations I have made to disclose health information that are inconsistent with this authorization. This document shall be governed by Florida law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No I 04-191, and the Medical Records Access Act, MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Florida law and HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I am at least 18 years old and of sound mind.

5. Any Billing for Medical Records is solely the patient's responsibility.

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PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE DATE

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Florida Medical Marijuana Institute
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Cancellation/No Show Payment Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we were unable to schedule you for a visit, due to a full schedule.

Cancellations

It is our policy that all appointments be cancelled at least “24" hours in advance of the appointment. If an appointment is not cancelled 24 hours in advance, you will be charged the full appointment cost. Your credit or debit card on file will automatically be charged on the day of the cancellation if you are cancelling less than 24 hours business hours prior to your appointment. All patients will have the opportunity to show proof an “urgent” reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for late cancellations.

No Show

Patients who "No Show" their visit will be charged for that visit in full, and will need to prepay future appointments. Your credit or debit card on file will automatically be charged on the day you "No Show" your appointment. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for not showing for their scheduled appointment.

Follow Up Visits

Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider. Patients who miss the scheduled follow up visits will be charged the $125 for the missed appointment

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We request you come 30 minutes early to your first appointment to account for traffic and to complete the required paperwork and 15 minutes before your future appointments. If you are 15 minutes past your scheduled time, your provider may not be able to complete a full visit or we will do our best to accommodate you and fit you into the schedule later in the day. If you cannot complete your visit you will be charged for the full visit and you will be required to book a new visit.

Account Balances

We will require that patients pay their account balances to zero (0) prior to receiving further services by our practice. We also require payment be rendered prior to services.

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Acknowledgement of Receipt of Cancellation/No Show Payment Policy

I, ____ do hereby acknowledge receipt of a copy of the Cancellation And NO Show Payment Policy of Florida Medical Marijuana Institute.

Signature: ____ Date ____/_____/_____

Authorization To Charge My Credit/Debit Card

I, ____ authorize Florida Medical Marijuana Institute to keep my credit/debit card information on file and charge my credit/debit card in the event that I do not cancel my appointment with a 24 business hour notice OR no show for my scheduled appointment(s).

Signature: ____ Date ____/_____/_____

Patients not authorizing Florida Medical Marijuana Institute to keep theircredit/debit card information on file will be required to prepay all follow-up and recertification visits.

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PATIENT REASONS FOR THE NEED OF THC

In your own words, please describe why you feel that THC will benefit you

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Patient Health Questionnaire (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question/

Name: ___________________________ Age: ____ Sex: __Female__Male Today's Date: ____/_____/_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not Bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain			
b. Back pain			
c. Pain in your arms, legs, or joints (knees, hips, etc.)			
d. Menstrual cramps or other problems with your periods			
e. Pain or problems during sexual intercourse			
f. Headaches			
g. Chest pain			
h. Dizziness			
i. Fainting spells			
j. Feeling your heart pound or race			
k. Shortness of breath			
l. Constipation, loose bowels, or diarrhea			
m. Nausea, gas, or indigestion n. Anxiety Issues o. Alcohol or Drug Use	_________	_________	_________

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2. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling or staying asleep, or sleeping toomuch				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself- or that you are a failure orhave let yourself or your family down				
g. Trouble concentrating on things, such as reading thenewspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless thatyou have been moving around a lot more than usual				

If you checked YES to ANY problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		
PROBLEMS: (Degree of difficulty/severity) Please Explain:		

1.____

2.____

3.____

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HIPPA Privacy Statement

Your Information. Your Rights. Our Responsibilities.

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 and sign on the last page.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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 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.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, 0.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.

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.

YourChoices

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

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.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

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. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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 dies.

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.

How do we typically use or share your health information?

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

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.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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.

The Effective Date of the Notice: ______________________________

Patient Signature Date

Contact Information

Florida Medical Marijuana Institute

224 Mariner Boulevard, Spring Hill, FL 34609352-686-9779 Phone352-686-0727 Fax