Fonticiella
MEDICAL CLINIC INC.
1000 West Kingshighway, Suite 12, Paragould, AR 72450
Phone (870) 236-3930 Fax (870) 239-8065

Medical Marijuana New Patient Intake Packet

Thank you for your interest in our clinic. It is our goal at Fonticiella Medical Clinic to make the certification process for Medical Marijuana as smooth as possible. To qualify for the Arkansas Medical Marijuana Program, you need to be diagnosed with one or more of the following qualifying conditions in order to get a medical marijuana card in the state of Arkansas:

-Cancer	-Post Traumatic Stress Disorder (PTSD)	-Alzheimer's Disease
-Intractable Nausea	-Persistent Muscle Spasms	-Tourette's Disease
-HIV+ status/ AIDS	-Severe Arthritis	-Glaucoma
-Hepatitis C	-Epilepsy/Seizures	-Intractable Pain
-Ulcerative Colitis	-Peripheral Neuropathy	-Fibromyalgia
-Crohn's Disease	-ALS	

Prior to your initial appointment being scheduled, you'll be required to supply us with a valid Arkansas driver's license or state ID card. If you do not possess a valid Arkansas driver's license or state ID, you may submit a copy of an Arkansas voter registration card. We also require proof of residency, such as a copy of a utility bill in your name including an Arkansas address. For minor patients, the parent or designated legal representative must submit proof of residency of the parent or legal representative. We also require all patients to complete the New Patient and Intake Form prior to be scheduled. Once the required information is received and reviewed, we will contact you to set up your appointment.

To streamline your initial appointment, we will require your most current medical records from the last 12 months or anything pertinent to your medical condition for which you seek certification for medical marijuana. You can ask your current primary care physician or specialist to fax or mail us a copy of your records to the address and fax number listed above. You can request a records release form at the front desk if needed. Note that your doctor's office may charge you to send us records and this is your financial responsibility. Records will need to be received prior to your first appointment or the appointment may be rescheduled.

What do I need to bring to my appointment?

1. Fees-please refer to the Financial Policy on page 7 included in this packet for rates
2. The Arkansas Department of Health Medical Marijuana Physician Written Certification Form -this can be found on their website: https://www.healthy.arkansas.gov/images/uploads/pdf/Physician_Written_Certification_Form.pdf

What happens after I get my certification?

It will be patient responsibility to complete their application and submit the certification to the Arkansas Department of Health. Regulations state the physician certification is valid for 30 days. If you get a certification and fail to submit it to ADH within 30 days, you must get a new certification, which will require another appointment. If you have questions regarding the application process or status of application, please direct them to Arkansas Department of Health at 501-682-4982. It is also patient responsibility to find out information or locations of dispensaries. We do not keep this information in the clinic.

If you have any questions regarding your appointment with us, please feel free to call us at the number above!

FONTICIELLA MEDICAL CLINIC, INC. NEW PATIENT AND INTAKE FORM
MEDICAL MARIJUANA ("MMJ") CERTIFICATION

First Name_____ Middle Initial_____ Last Name_____

Social Security Number_____ Date of Birth_____

Race: ☐ White ☐ African American ☐ Asian ☐ American Indian ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Gender: ☐ Male ☐ Female

Email Address_____

Home Phone_____ Cell Phone_____

Physical Address_____

City_____ State_____ Zip Code_____

Mailing Address (if different than the above)_____

City_____ State_____ Zip Code_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed/Widower

Employment Status: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired

Employer Name/ Address_____

Emergency Contact Information:

Name_____ Relationship _____

Phone Number _____

Primary Care Physician Information:

Name _____ Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Primary medical condition for which MMJ is requested_____

Please describe when this condition started _____

_____

Other Medical Problems and/or symptoms:

1. _____
2. _____
3. _____

Please describe the intensity/frequency of symptoms _____

Please describe any previous tests (X-ray, CT scan, MRI, EMG, etc) or treatments (Surgery, Injections, Medications and Therapy, etc) you have had for the treatment of this/these condition(s): _____

_____

Please describe what makes the symptoms worse: ☐ Sitting ☐ Standing ☐ Rest ☐ Heat ☐ Cold ☐ Walking ☐ Exercise ☐ Sex ☐ Touch ☐ Other (describe)_____

Please describe what makes the symptoms better: ☐ Sitting ☐ Standing ☐ Rest ☐ Heat ☐ Cold ☐ Walking

☐ Exercise ☐ Sex ☐ Touch ☐ Other (describe)_____

Medical Information:

****Please list ALL medications/herbs you are taking. Use the back page of this packet if needed. ****

Medication/Supplement/Herb	Dosage	How often do you take this medication?

Have you had any surgeries? If yes, please explain _____

_____

If female, is there any possibility you could be pregnant? ☐ Yes ☐ No ☐ Unsure

Date of last period _____

Allergies: ☐ None known ☐ Medication Allergy _____

☐ Food Allergy _____

Functional History: How do your symptoms affect your daily activities? _____

_____

Do you use any assistive devices? ☐ No ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair

Is there a family history of any medical problems? If yes, please explain: _____

_____

Your last Medical Doctor or Clinic Visit:

Name _____ Phone _____ Fax _____

Address_____

City _____ State _____ Zip Code _____

Date and Reason for visit _____

Date and Reason for upcoming visits _____

If there is no visit in the past 10 years, please state why _____

(If you DO NOT remember your last doctor's visit, please write I DO NOT REMEMBER across this section)

Social History:

Do you have any legal matters relating to your medical condition? ☐ Yes ☐ No

Are you on parole or probation or have a pending cannabis legal problem? ☐ Yes ☐ No

Smoking History: ☐ No ☐ Ex-smoker, Year stopped? _____ ☐ Current, Year started? _____

Alcohol History: ☐ No ☐ Current, please describe habits: _____

Drug Use: ☐ No ☐ Current ☐ Past ☐ Cocaine ☐ Marijuana ☐ Heroin ☐ Other_____

Have you ever been addicted to prescription drugs? ☐ Yes ☐ No

Cannabis History:

Are you currently using marijuana? ☐ Yes ☐ No When did you start? _____

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other(please describe) _____

Delivery system: ☐ Pipe ☐ Joint ☐ Vaporizer ☐ Tincture ☐ Food

Have you had any adverse effects from cannabis? ☐ Yes ☐ No

Please describe adverse effects if answered yes _____

Does cannabis provide relief from your medical symptoms/problem? ☐ Yes ☐ No

---

I, _____, am here to see Dr. Fonticiella today because I request an evaluation for a medical marijuana certificate. I believe that the use of medicinal use of marijuana will relieve my symptoms. I have the following symptoms and/or diagnoses:

(Circle all that apply below)

	Symptoms		**Symptoms**
	Anxiety / Stress/ Insomnia / Rage		Nausea/ Vomiting/ Abdominal Pain/ Chronic Stomach Upset
	Depressed Feelings/ Suicidal (now)?		Difficulty Gaining Weight/ Lack of Appetite
	Headaches		Chronic Cough
	Back Pain/ Upper Mid Lower		Chest pain (now?) / Shortness of Breath
	Neck Pain / TMJ Dysfunction		Skin Irritation
	Joint Pain:_____		Dizziness / Vision Problems / Vertigo
	Muscle Spasms:_____		Urinary Problems
	Numbness or tingling in limbs		Erectile Dysfunction / Libido
	Menstrual Cramps / Hot Flashes		History of Addiction to:_____
	Other:_____		Other:_____
	Diagnosis by your Doctor		**Diagnosis by your Doctor**
	AIDS / HIV / Wasting Syndrome		Asthma /COPD / Pulmonary Fibrosis
	ADD / ADHD (attention hyperactivity disorder)		Arthritis: Rheumatoid / Osteoarthritis / Psoriatic / Gout
	Bipolar / Depression / OCD		Cancer of:_____
	Anxiety / Panic Disorder		Diabetes: Controlled / Uncontrolled HgbA1c? _____
	Schizophrenia / Schizoaffective Disorder		Restless Leg Syndrome
	PTSD (post-traumatic stress disorder)		Epilepsy / Seizures / Traumatic Brain Injury / Stroke
	Heart Disease / High Blood Pressure/ A-Fib		Hepatitis B / Hepatitis C / Cirrhosis
	Alzheimer's / Dementia		Kidney Disease/ Chronic Interstitial Cystitis/ Polycystic Kidney
	Migraine / Tension Headache		Multiple Sclerosis / Cerebral Palsy / Parkinson's / ALS
	Stomach Ulcers / Ulcerative Colitis / GERD		Fibromyalgia/ Lupus/ Lyme Disease / Autoimmune Disorder
	Crohn's Disease / IBS / Cyclic Vomiting		Psoriasis / Eczema/ Other: _____
	Menopause / Polycystic Ovarian Syndrome		Neuropathy of:_____
	Thyroid Disease / Hashimoto's		Glaucoma/ Intraocular Pressure / Macular Degeneration

Patient Statement Regarding Primary Diagnosis and Medical Records:

Have you seen a doctor or been to a clinic for your medical symptoms/problems? ☐ Yes ☐ No

1. If you answered YES, please provide us with a copy of your medical records, x-rays, labs, and prescriptions from your treating physician/ clinic (the doctor you listed on page 2).
2. If you answered YES but CANNOT provide the medical record copies, then please provide the following information:

   I cannot provide the records because: _____

Your personal statement regarding the above facts:

I, _____, confirm that the information provided by me regarding my diagnosis and medical records is true and correct.

Patient Signature_____ Date _____

Disclosures and Conditions:

Please initial in each box indicating you have read, understand, and affirm the following statements:

	Based on my beliefs and awareness of researched scientific evidence of the benefits of medical cannabis, I request that Dr. Fonticiella evaluate me for a certificate to use medical cannabis. This would enable me to legally obtain medical marijuana to use for treatment for my medical condition(s).
	If medical cannabis adversely affects my health, I will stop using medical cannabis. I assume all risk for the use of medical cannabis.
	I agree to obtain medical follow-up at my personal medical doctor's office or obtain a personal doctor because I have none now and to return to this office for follow-up as recommended by Dr. Fonticiella. I understand this is an obligation on my part for the continuity of care.
	I agree NOT TO DRIVE or operate heavy equipment while using medical cannabis.
	I understand it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of medical cannabis.
	I DO NOT plan or intend to use Dr. Fonticiella's evaluation for the purpose of illegally obtaining medical cannabis.
	I understand that I MUST be an Arkansas resident to obtain an approval or certification for the use of medical cannabis under Arkansas Law. I affirm that I have a serious medical condition that adversely affects my quality of life.
	I understand that Dr. Fonticiella is not recommending the use of medical cannabis, but only certifying that I have a qualifying condition to use medical cannabis. I am voluntarily requesting this evaluation and understand that I am solely responsible for payment of services.
	I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
	It should be made absolutely clear that Dr. Fonticiella, Fonticiella Medical Clinic, Inc. staff or representatives of this clinic are neither providing medical cannabis, nor are they encouraging any illegal activity in my obtaining or using medical cannabis.
	Furthermore, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold Dr. Fonticiella, Fonticiella Medical Clinic, Inc. staff or any agents of this clinic, free and harmless of any liability resulting from the use of medical cannabis.

I have read, understand and affirm all the above statements.

Patient Signature_____ Date_____

Fonticiella Medical Clinic, Inc. Consent for Use and Disclosure of Health Information

Patient Name_____ Date of Birth_____

Please read the following statements carefully:

- By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and statement fees and charges that may apply, also to disclose healthcare operations.
- Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the use and disclosure we may make of your protected health information, and of other important matters of your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
- We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
- You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting:
  Sonia Fonticiella
  Telephone: (870) 236-6930 Fax (870) 239-8065
  Address: 1000 West Kingshighway, Suite 12 Paragould, AR 72450
- **Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents
(Print Patient Name or Legal Guardian if minor)
of this consent form and your Notice of Privacy Practices. I understand, that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health information to carry out treatment, as well as payment activities, statement fees and charges that may apply, and healthcare operations.

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Print Patient Name or Legal Guardian if minor)

By signing below, you are acknowledging you have read, understand, and affirm the above statements and that you have been given a copy of our Notice of Privacy Practices as noted above.

Patient or Legal Guardian Signature _____Date_____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative Name_____ Relationship to patient_____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement ☐ Other (please specify)_____

Notes:_____

Fonticiella Medical Clinic, Inc. Financial Policy for Medical Marijuana ("MMJ")

We at Fonticiella Medical Clinic, Inc. want to make your visit here as professional and pleasant as possible. We value our patients' health and strive to make your experience with us reflect that.

Unfortunately, medical cannabis/marijuana is still federally illegal, therefore NO insurance company has elected to cover cannabis-related treatments or related office visits. All fees for services provided are to be paid at the time of service in full. We accept cash payment only. No checks or credit/debit card payments will be accepted.

Due to insurance companies not covering cannabis-related treatments or related office visits, please understand this means no other medical problems, issues, or refills can be discussed during your visit related to MMJ. This also means, if you happen to be an existing patient here for your regular office visit or a sick visit, MMJ cannot be discussed, or insurance will deny the claim and then you will be financially responsible for that charge.

The fee structure for MMJ- related visits are as follows:

- New Patient Certification is $250.00
- Renewal Patient Certification is $200.00
- Follow-up Patient Visit is $100.00 (the first year of certification, patients will be required to follow-up every 3 months and then transition to 6 months after the renewal)
- Veterans (First Visit only) $225.00

By signing this document, I am acknowledging that I have read and understand the above financial policy.

Patient Signature_____ Date_____