An oz. of Wellness Healthcare

PATIENT MEDICAL HISTORY INTAKE FORM

Name: _____ DOB: _____ SS#: _____

Gender: ____ Male ____ Female Phone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about us? _____ Weight: _____

For what conditions do you seek medical cannabis? _____

Please list all doctors, including their name, address and phone number that you have seen in the last five years for any condition related to your current health and your request for medical cannabis:

Doctor Name	Address	Phone/Fax Number	Reason for Visit

Past Medical History (Please mark all that apply):

_____ AIDS	_____ IBS	_____ Anorexia
_____ ALS	_____ HIV	_____ Bulimia
_____ Alzheimer's Disease	_____ Auto-immune Disorder	_____ Brain disorders
_____ Intestinal Disorder	_____ Blood Disorders	_____ Prostate Disease
_____ Ulcers	_____ Disc Injury	_____ Hearing Loss
_____ Colitis	_____ Osteoporosis	_____ Tinnitus
_____ Crohn's Disease	_____ Scoliosis	_____ Epilepsy/Seizures/Spasms
_____ Cachexia/Wasting Syndrome	_____ Sciatica	_____ Diabetes

Occupation: _____ Do you live alone: _____ Yes _____ No

Do you smoke cigarettes: _____ No _____ Yes If so, how many packs a day? ____

Do you drink _____ No _____ Yes If so, how many drinks per week? _____

Are you or planning on becoming pregnant? _____ No _____ Yes ***If so, THC is contraindicated for pregnant women and nursing mothers***

Past Medical History – Continued

_____ Weight Loss/Gain (lbs___) reason: _____	_____ Heart Disease – Specify: _____
_____ Chronic Pain – specify: _____	_____ Circulation problems (stroke, phlebitis, etc.)
_____ Fibromyalgia	_____ Lung Disease – Specify: _____
_____ Migraine	_____ Asthma
_____ PTSD	_____ Shortness of Breath
_____ Anxiety	_____ COPD
_____ Depression	_____ Cancer – Specify: _____
_____ Bipolar	_____ Breast Lesions
_____ Schizophrenia	_____ Liver Disease – Specify: _____
_____ Kidney/Bladder Disease – Specify: _____	_____ Hepatitis A/B/C – Specify: _____ ____
_____ Insomnia	_____ Glaucoma/Vision Problems – Specify _____
_____ Sleep Apnia	_____ MS/ALS
_____ Endocrine Problems – Specify: _____	_____ Parkinson's Disease
_____ Rheumatic Disease - Specify: _____	_____ Distonia

Surgical History: Please list any surgeries and date of such surgery: _____ None

Date of Surgery	Type of Surgery or Condition

Note non-surgical treatments received/receiving for the condition(s) for which you seek medical cannabis:

_____ Physical Therapy	_____ Pain Specialist	_____ Orthopedist
_____ Oncologist	_____ Injections	_____ Psychologist
_____ Heart Specialist	_____ Endocrinologist	_____ Chiropractor
_____ Social Worker	_____ Neurologist	_____ Acupuncture
_____ Psychiatrist	_____ Other – Specify: _____	

Activities of Daily Living Assessment: Please check if any of the following activities are substantially limited (i.e., pain/weakness/impaired strength or ability) by the medical conditions for which you seek a medical cannabis recommendation:

_____ caring for myself	_____ hearing	_____ walking
_____ bending	_____ learning	_____ thinking
_____ social interaction	_____ performing manual tasks	_____ eating
_____ standing	_____ speaking	_____ reading
_____ communicating	_____ operation of bodily function	_____ seeing
_____ sleeping	_____ lifting	_____ breating
_____ concentrating	_____ working	_____ other – Specify: _____

Medications: List all medications that you are currently taking:

Medication	Dosage	Times Per Day	Reason For Taking

List any medications to which you are allergic:

Medication	Type of Reaction

Supplements and Vitamins: List all supplements and vitamins that you are currently taking (include CBD)

Supplement/Vitamin	Dosage	Times Per Day	Reason For Taking

GOALS: Please detail what you hope to have as an outcome by using medical cannabis: _____

_____

_____

CONSENT TO TREATMENT -- ASSIGNMENT OF BENEFITS FINANCIAL RESPONSIBILITY

NAME OF PATIENT: _____
(Please print your name)

CONSENT FOR TREATMENT: Knowing that I (or the patient indicated at the top of this form) desire evaluation and/or treatment at any An oz. of Wellness Healthcare ("AOWH") location, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical or surgical treatment by physicians and staff members of AOWH and other healthcare providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties have been made to me as a result of my examination or treatment at AOWH. I acknowledge that treatment at AOWH is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive provided by a primary care physician or other specialized physician. In order to provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician, including compliance with medications/supplements, discharge instructions and reevaluation with follow up or referral physicians. I agree to return for follow up treatment with AOWH or seek care from my other physicians or from in an Emergency Department of a hospital, if my condition materially worsens. I further agree to hold AOWH, its managers, employees and contractors harmless from any liability if I fail to comply with the above conditions. This consent shall remain in force until it has been specifically revoked.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I authorize direct remittance of all insurance, including Medicare (if I am a Medicare beneficiary) to AOWH for all covered medical services and supplies provided to me during all courses of treatment and care provided by AOWH and/or its affiliated entities or otherwise at its direction. I understand and agree that this Assignment constitutes a continuing authorization maintained on file with AOWH, which will authorize and allow for direct payment to AOWH of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by AOWH.

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to AOWH and/or its affiliated entities for any changes not covered by healthcare benefits. It is my obligation to notify AOWH of any changes in my health-care coverage. I understand that by signing this form, I am accepting financial responsibility for all payment for medical services and/or supplies that I receive.

Patients at AOWH will be treated regardless of race, color, age, national origin, disability or religion. However, AOWH reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior, or any other reason at the discretion of the physician on duty.

Signature of Patient/Patient's Representative: _____ Date: _____

Representative's relationship to Patient: _____

Reason Why Patient Cannot Consent: _____

Witness: _____

AN OZ. OF WELLNESS HEALTHCARE

AVALON PARK
14807 E. Colonial Dr., # 112
Orlando, FL 32826
(407) 917-2253

BOCA RATON
9045 La Fontana Blvd., #114
Boca Raton, FL 33434
(561) 406-4954

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this consent form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below. Protected Health Information is individually identifiable information we create or receive, including demographic information, information relating to your physical or mental health and the provision of healthcare services to you, and information regarding the collection of payment for the services provided to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this consent form. As provided in our Notice, the terms of the Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting us directly or viewing a copy in the forms section of our website at http://anozofwellness.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound by our agreement. If you wish to make a restriction, please email us. If you do not sign this Consent, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment, or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent. You have the right to revoke this Consent, in writing, except where we have already made disclosures in reliance upon your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

_____ _____

PRINT PATIENT NAME DATE OF BIRTH

_____

PRINT PATIENT PERSONAL REPRESENTATIVE NAME

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE OF SIGNATURE

Permission Regarding Disclosure of Your/Your Child's Healthcare Information

I hereby authorize An oz. of Wellness Healthcare to speak with the individual(s) named below regarding my or my child's protected health information (optional).

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____

Date of Birth: _____ SS#: _____ Phone #: _____

Patient Address: _____

***The undersigned authorizes An oz. of Wellness Healthcare to obtain his/her medical records from*:**

Name: _____

Address: _____

Phone Fax: _____

Please DO NOT release the following: _____

_____

***The undersigned authorizes An oz. of Wellness Healthcare to release his/her medical records to*:**

Name: _____

Address: _____

Phone Fax: _____

Please DO NOT release the following: _____

_____

- Medical records include any and all federal and state protected information without limitation to include diagnosis, treatment, and/or examination related to mental healthcare, drug and/or alcohol use, HIV/AIDS testing, and sexually transmitted diseases.
- By signing this release, I understand that this authorization will remain in effect for 90 days or until revoked in writing.
- I understand that state law prohibits the re-disclosure of the information disclosed to the person/entity listed above without my further authorization, but that An oz. of Wellness Healthcare cannot guarantee that the recipient of the information will not re-disclose it.
- I hereby release An oz. of Wellness Healthcare and its managers, employees and agents from any liability that may arise from the release of information that I have allowed.

IF SENDING RECORDS TO US, PLEASE FAX TO: (713) 489-9352

X _____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

IF THE RECORDS ARE MORE THAN 30 PAGES, KINDLY MAIL TO THE CIRCLED LOCATION

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Medical Marijuana Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient or the patient's parent or legal guardian if the patient is a minor must initial each section of this consent form to indicate that the physician explained the information and, along with the qualifying physician, must sign and date the informed consent form.

This consent form contains three parts. Part A must be completed by all patients. Part B is for patients under the age of 18, who have a terminal condition, when the medical marijuana is being ordered in a smokable form. Part C is the signature block and must be completed by all patients.

Part A: Must be completed for all medical marijuana patients – ***please initial each highlighted blank***

a. The Federal Government's classification of marijuana as a Schedule I controlled Substance.

____ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances 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 Florida, which have modified their state laws to treat marijuana as a medicine.

____ When in the possession or under the influence of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

b. The approval and oversight status of marijuana by the Food and Drug Administration.

____ 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 federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

c. The potential for addiction.

____ Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think I may be developing a dependency on marijuana, I should contact my doctor.

d. The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.

____ The use of marijuana can affect coordination, motor skills, and cognition, i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of crashing, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence".

e. The potential side effects of medical marijuana use.

____ 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, may affect the production of sex hormones that lead to adverse effects, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than 25, can result in long term problems with attention, memory, learning, drug abuse, and schizophrenia.

There is substantial evidence of a statistical association between long-term cannabis smoking and worsening respiratory symptoms and more frequent chronic bronchitis episodes. Smoking marijuana is associated with large airway inflammation, increasing airway resistance, and lung hyperinflation. Smoking cannabis, much like smoking tobacco, can induce levels of volatile chemicals and tar in the lungs that may raise concerns about the risk of cancer and lung disease.

____ I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

____ I agree to contact my doctor 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 my doctor 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.

f. The risks, benefits, and drug interactions of marijuana.

____ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

____ 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 contact my doctor immediately or go to the nearest emergency room.

____ Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences. I agree to follow the directions of my doctor regarding the use of prescription and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

____ Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact my doctor immediately or go to the nearest emergency room if these symptoms occur.

____ I understand that medical marijuana may have serious risks and may cause low birth weight or other abnormalities in babies. I will advise my doctor if I become pregnant, try to get pregnant, or will be breastfeeding.

g. **The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.**

_____ Cancer

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancers, including glioma. There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation process. Due to a lack of recent, high quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- There is conclusive evidence that oral cannabinoids are effective anti-emetics in the treatment of chemotherapy-induced nausea and vomiting. There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer associated anorexia cachexia syndrome and anorexia nervosa.

_____ Epilepsy

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy. Recent systematic reviews were unable to identify any randomized controlled trials evaluation the efficacy of cannabinoids for the treatment of epilepsy. Currently available clinical data therefore consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

_____ Glaucoma

- There is limited evidence that cannabinoids are an ineffective treatment for improving intraocular pressure associated with glaucoma. Lower intraocular pressure is a key target for glaucoma treatments. Non-randomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systemic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited. However, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular pressure. To date, those studies showing positive effects, have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

_____ Positive Status for Human Immunodeficiency Virus

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS. There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

_____ Acquired Immune Deficiency Syndrome

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS. There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

_____ Post Traumatic Stress Disorder

- There is limited evidence (a single, small fair-quality trial) that Nabilone is effective for improving symptoms of post traumatic stress disorder. A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid Nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived forms) and increased severity of post-traumatic stress disorder symptoms among individuals with post traumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

_____ Amyotrophic Lateral Sclerosis

- There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis. Two small studies investigated the effect of Dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the sample sizes were small, the duration of the studies was short, and the dose of Dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

_____ Crohn's Disease

- There is insufficient evidence to support or refute the conclusion that Dronabinol is an effective treatment for the symptoms of irritable bowel disease. Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of irritable bowel diseases, including Crohn's Disease.

_____ Parkinson's Disease

- There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's Disease or the levodopa-induced dyskinesia. Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to placebo in ameliorating the side effects of Parkinson's disease. A seven patient trial of Nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

_____ Multiple Sclerosis

- There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity. Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, Nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

_____ Medical Conditions of the Same Kind or Class as or as Comparable to the Above Qualifying Medical Conditions

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.
- The summary is attached to this informed consent as Addendum A.

_____ Terminal Conditions Diagnosed by a Physician Other Than the Qualified Physician Issuing the Physician Certification

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.
- The summary is attached to this informed consent as Addendum A.

_____ Chronic Nonmalignant Pain

- There is substantial evidence that cannabis is an effective treatment for chronic pain in adults. The majority of studies on paid evaluated Nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flower form provided by the National Institute on Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms. While the use of cannabis for the treatment of pain is supported by well-controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

h. That the Patient's De-Identified Health Information Contained in the Physician Certification and Medical Marijuana Use Registry May be Used for Research Purposes.

_____ The Department of Health submits a data set to the Consortium for Medical Marijuana Clinical Outcomes Research for each patient registered in the Medical Marijuana Use Registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient.

PART B. Ordering smokable marijuana for a terminal patient under 18.

_____ Initial here if you are not a terminal patient under 18 who will be receiving medical marijuana in a smokable form. After initialing here, complete Part C.

If the patient is under 18, has a terminal condition, and will be receiving medical marijuana in a smokable form, please review and initial the remainder of Part B before completing Part C.

Respiratory Health

_____ Exposure to tobacco smoke and household air pollution consistently ranks among the top risk factors not only for respiratory disease burden but also for the global burden of disease. Given the known relationships between tobacco smoking and multiple respiratory conditions, one could hypothesize that long-term cannabis smoking leads to similar deleterious effects of respiratory health, and some investigators argue that cannabis smoking may even be more harmful than that of tobacco smoking. Data collected from 15 volunteers suggest that smoking one cannabis joint can lead to four times the exposure to carbon monoxide and three to five times more tar deposition than smoking a single cigarette.

Cognitive and Psychosocial Development

_____ Researchers are still studying the long term health effects of marijuana. Most people agree that marijuana use hurts adolescents more than adults. It is during the period of adolescence and young adulthood that the neutral substrates that underlie the development of cognition are most active. Adolescence marks one of the most impressive stretches of neural and behavioral change with substantial protracted development in terms of both brain structure and function. As a result, cannabis and other substance use during this period may incur relatively greater interference in neural, social, and academic functioning compared to late developmental periods.

- There is moderate evidence of a statistical association between acute cannabis use and impairment in the cognitive domains of learning, memory and attention.

- There is limited evidence of a statistical association between sustained abstinence from cannabis use and impairments in the cognitive domains of learning, memory and attention.

- There is limited evidence of a statistical association between cannabis use and impaired academic achievement and education outcomes.

- There is limited evidence of a statistical association between cannabis use and increased rates of unemployment and/or low income.

- There is limited evidence of a statistical association between cannabis use and impaired social functioning or engagement in developmentally appropriate social roles.

- Less blood flow to parts of the brain.

_____ Addiction

Marijuana, like some other brain-altering substances, can be addictive. Nearly one in 10 marijuana users will become addicted. Starting to use marijuana at a younger age can lead to a greater risk of developing a substance use disorder later in life. Adolescents who begin using marijuana before age 18 are four to seven times more likely than adults to develop a marijuana use disorder.

PART C. Must be completed for all medical marijuana patients

_____ 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. I acknowledge that my doctor has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

My doctor has also informed me of the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that my doctor informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

My doctor has explained the information in this consent form about the medical use of marijuana.

Patient (print name): _____

Patient signature or signature of the parent or legal guardian if the patient is a minor – please sign and date:

_____ Date: _____

I have explained the information in this consent form about the medical use of marijuana to _____ _____ (print patient name).

Qualified Physician Signature:

_____ Date: _____

Witness:

_____ Date: _____

Supplemental Medical Marijuana Consent Form and Agreement

I understand that unless I am visiting An oz. of Wellness Healthcare ("AOWH") for purposes other than obtaining a medical marijuana certification, that the encounter(s) that I will have with my AOWH physician will be limited to his or her diagnosis and certification of a qualifying condition that I may have that entitles me to use medical marijuana under Florida law (my "Qualifying Condition").

I acknowledge that AOWH physicians will only be conducting limited, if any, diagnostic testing to aid them in their certification and diagnosis of my Qualifying Condition and that they will be relying on those medical records of mine that may they obtain, their limited diagnostic evaluations, if any, and my self reporting of, among other things, symptoms that I may be experiencing, medications that I am taking, my family history, and other factors to do so, which shall be accurate and complete. I acknowledge and agree that they may rely on my self-reporting of: i) the medications and supplements that I may be taking; ii) medical conditions and/or symptoms that I may have; iii) any known allergies that I may have; iv) my medical and family history; v) my lifestyle factors; and vi) the physical and emotional support systems that I may have, without any obligation or duty to independently investigate or verify the same other than reviewing the Florida Drug Monitoring Program, as required by Florida law and I have no expectation that they will conduct any such independent investigation or verification. I further acknowledge that: a) the medical records supplied to them by me or through their efforts may not be comprehensive; b) I have no expectation that they will be reviewed for any purpose other than certifying and diagnosing my medical condition so that I may obtain a medical marijuana certification; c) that I will seek the treatment of a primary care or specialist physician if, in the opinion of my AOWH Physician, the results of my medical marijuana evaluation so dictate; d) that AOWH and its physicians are under no obligation or duty to inquire or determine whether or not I have sought such follow-up treatment; and e) that the inaccurate self-reporting of those factors described above, whether by omission or inclusion, would prevent the rendering of an accurate diagnosis or evaluation, and/or assessment of health risks requiring a referral to another physician.

I represent and warrant that I will not misrepresent my medical condition (by way of inclusion or omission) or my Florida residency status in order to obtain a medical marijuana recommendation and it is my intent to use marijuana only as needed for the treatment of my qualifying medical condition, and not for recreational or non-medical purposes. In the event that I misrepresent my medical condition or residency status, whether intentionally, negligently or inadvertently, I agree to indemnify and hold AOWH and its recommending physicians, staff, officers, managers, employees, contractors and agents harmless from any and all losses, charges, damages, or expenses that they may suffer or incur as a result of such misrepresentation. By signing below, I also release AOWH, its physicians, staff, officers, managers, employees, contractors, and agents of any and all liability in the event that I have intentionally, negligently, or inadvertently failed to accurately self report any information pertaining to my physical or mental health to them.

Notwithstanding the foregoing, if AOWH or their staff provide me with any assistance in connection with the completion and/or submission to the Office of Medical Marijuana Use (the "OMMU") of my Medical Marijuana ID Card application after my basic demographic information has been supplied to the OMMU, I acknowledge that I am solely responsible for the accuracy and completeness of the information provided in said application and that I have an obligation to review such information and correct any inaccuracies before it is submitted. I also 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 and acknowledge that AOWH and it's staff and physicians are not providing this information to me, and are not providing legal advice to me.

Additionally, I have been informed of and understand the following:

Risks, Benefits, Interactions and Contraindications – *please initial each highlighted blank*

____ The long and short-term risks, benefits and drug interactions of marijuana, and the respective routes of its administration are not fully understood.

____ I have advised my AOWH physician of all prescription medications, supplements and other substances that I am currently taking and plan to take so that interaction risks may be properly evaluated, and acknowledge that this is especially significant in the case of opioids as their effects may be enhanced by the use of medical marijuana.

____ If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my other treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by my other treating physician(s). I also understand that it is important to regularly see and follow up with my primary care and specialist providers and that it is important to routinely have my blood work tested.

____ The known risks and benefits of medical marijuana have been explained to me by my AOWH physician, and have been discussed with me as they relate to my Qualifying Condition(s). Some of these risks are disclosed in attachment A.

____ Marijuana passes through the placenta and can be found in breast milk if consumed while pregnant or nursing and can adversely affect the health or development of an unborn or nursing child. Its use is contraindicated for pregnant and nursing mothers.

____ Medical marijuana is contraindicated for patients with schizophrenia or who may have a family history of schizophrenia and the risks of its use by adolescents and the elderly may outweigh the medical benefits of such use. By signing below I acknowledge that I have not been diagnosed with schizophrenia and do not have a family history of schizophrenia. I further acknowledge that I will advise AOWH if I am subsequently diagnosed with schizophrenia.

____ AOWH and its staff have advised me that: i) a 1999 Institute of Medicine Report concluded that the side effects of cannabinoid drugs are within the acceptable risks associated with approved medications and that most of its associated risks are associated with the smoking of cannabis; and that ii) there are no known cases of lethal overdose. I have also been advised that unless my use of medical cannabis is contraindicated by any of the conditions described herein that it is the opinion of my AOWH physician that the potential benefits of its use outweigh its potential risks to me.

____ The effects of medical marijuana and the impairment that its use can cause can last long after its use has stopped, especially with chronic use. I acknowledge that I have been advised to avoid operating a motor vehicle or heavy machinery within 6 hours of consuming cannabis or if I am otherwise impaired.

____ Medical marijuana and marijuana delivery devices should be secured and safeguarded, and kept away from children, domesticated pets and other animals.

____ The effects of orally administered medical marijuana may take several hours to be felt. Patients using orally administered medical marijuana, especially those taking edibles, must not exceed their recommended dosages.

____ While the risks associated with vaping are thought to be less than those associated with smoking, such risks are not fully understood and vaping may be damaging to your health. In particular, certain vaping products have been found to possibly cause serious lung damage and vaping may lead to difficulties when treating COVID-19 infections. I acknowledge that I have been advised that the devices, and processed and natural product that I intend to use for vaping, inhalation, or other routes of administration should only be purchased from a duly licensed MMTC, should not be tampered with, and should not be adulterated in any fashion.

____ In the event that I ask my AOWH physician to open smoking as an permitted form of medical cannabis consumption, I do so despite: i) the known negative health risks associated with the smoking of marijuana, which have been explained to me by my AOWH physician; and ii) any medical conditions that I may have. In such event, it is my belief that the overall benefits of medical marijuana, even if smoked, outweigh the risks to me that are associated with the smoking of it and I knowingly assume the risks associated with such use and I direct my AOWH physician to advise the Florida Department of Health and my doctor's medical board that smoking medical marijuana is an appropriate route of administration for me. I acknowledge and agree that any such determination is being made in light of and because of my willingness to assume the known risks associated with the smoking of medical marijuana.

____ I have been advised that consuming cannabis and obtaining a medical marijuana ID card could have an adverse effect on my ability to gain or retain employment or to obtain and retain a concealed carry permit.

Our Physician-Patient Relationship

____ I acknowledge that my doctor's recommendation of medical marijuana is made in reliance on, among other things: i) the statements that I have made to him or her regarding my condition, my need for relief, and/or the inability of other treatments to adequately treat my condition; ii) the certification of my diagnosis, which may be based on said statements or other supporting documentation; and iii) my acknowledgement of the risks and benefits associated with the use of medical marijuana. I also acknowledge that if my AOWH physician subsequently learns that the information that I have furnished is false or misleading, my recommendation for medical marijuana may be rescinded. I agree to promptly meet with my AOWH physician, and/or provide additional information in the event of any inaccuracies or misstatements in the information that I have provided. I further acknowledge that patients intentionally providing any dishonest or untruthful information will be discharged.

____ My AOWH physician has advised me of alternative treatments for any Qualifying Condition(s) that I may have that would entitle me to use medical marijuana under Florida law, as well as the respective risks and benefits of such treatments. Despite the fact that I may be registered in the Florida medical marijuana use registry, I have advised my AOWH Physician and hereby acknowledge that I may never decide to use medical marijuana for the treatment of any such Qualifying Condition.

____ I acknowledge that there are currently no universal or uniformly recognized dosing protocols for the use of medical marijuana in connection with the treatment of my Qualifying Condition(s), and, should I decide to use medical marijuana for the treatment of any such condition, will begin with the lowest dosage available for such treatment and titrate to higher doses needed to attain relief as my tolerance dictates. As such, I will be directly involved in the determination of the dosages that I take based upon the relief provided to me and my tolerance of the effects of medical marijuana.

____ Should I decide to use medical marijuana for the treatment of my Qualifying Condition(s), I acknowledge and understand that my doctor is not prescribing or ordering me to use medical marijuana in connection with such treatment and I am free to pursue any treatment with respect to my Qualifying Condition(s). Rather, I acknowledge that my doctor is merely certifying that I have one or more Qualifying Conditions and my doctor's recommendation represents his or her belief and medical opinion that the benefits of my use of medical marijuana in the manner that he or she has indicated would outweigh the risks of such use to me for the treatment of my Qualifying Condition(s).

____ I acknowledge that my doctor: i) has or will be conducting a physical examination and has or will be making a full assessment of my medical history while physically present in the same room with me (unless otherwise permitted by law); and ii) will be discussing the state's mandatory consent form as it relates to my Qualifying Condition(s). IF THIS STATEMENT HAS BEEN INITIALED PRIOR TO MY BEING SEEN BY THE PHYSICIAN AND ACTUAL FACTS SERVE TO CONTRADICT THIS STATEMENT, I WILL TAKE IMMEDIATE STEPS TO WITHDRAW MY INITIALS REGARDING THIS STATEMENT.

____ I understand that the recommendation of medical marijuana requires, among other things, the ongoing monitoring of my Qualifying Condition(s), my tolerance to medical marijuana, and any adverse reactions or drug interactions that I may experience. While I may be able to discuss some of these matters remotely or by phone, I may be required to meet personally with my AOWH physician again and may also be required to submit to a urinalysis before a new certification can be provided to me. If I fail to meet personally with my AOWH doctor upon his or her request, fail to submit requested medical records, or fail to submit to a urinalysis, I acknowledge that I could be discharged as a patient and that any current certification could be revoked.

____ I acknowledge that not all email and texting services are encrypted. This means that a third party may be able to access unencrypted transmissions and read the information in them. Even if encrypted, a third party may be able to access your healthcare information after you have read it. By signing below, I acknowledge that I have been made aware of the risks associated with unencrypted messaging such as unencrypted texts and/or emails and authorize AOWH to communicate with me and send my personal medical information via such unencrypted methods to the email address and phone numbers that I have supplied to AOWH. I also authorize AOWH to leave a message with any phone number that I have supplied to it, despite the fact that someone other than myself may retrieve the message.

____ I acknowledge and agree that this Supplemental Medical Marijuana Consent Form and Agreement shall remain in full force and effect until it has been terminated by me in writing. I further acknowledge and agree that all of the representations, acknowledgements and agreements that I have made herein shall survive any such termination.

Signatures

I hereby agree to and acknowledge the foregoing:

Patient (print name): _____

Patient signature or signature of the parent or legal guardian if the patient is a minor – please sign and date:

_____ Date: _____

I have explained the foregoing information to the foregoing patient:

Qualified physician signature:

_____ Date: _____

Attachment A

Additional Potential Side Effects

Marijuana is considered a "non-toxic herb". There have been no deaths from its ingestion or inhalation. You may experience some of the following side effects:

- A feeling of euphoria
- A feeling of relaxation
- Sleepiness
- Decreased short term memory
- Dry mouth
- Impaired perception, mobility, decision making, and motor skills
- Red eyes
- Increased appetite
- Decreased motivation
- Psychosis
- Paranoia
- Decreased pulmonary function

Uncomplicated marijuana intoxication rarely needs medical treatment but could cause, especially when mixed with other substances, among other things, high blood pressure, headache, chest pain, irregular heartbeat, seizures or stroke. Further side effects include, but are not limited to:

- Anxiety
- Dizziness
- Hypersomnia
- Hyperemesis syndrome
- Orthostatic hypotension (low blood pressure when suddenly standing)
- Tachycardia (increased heart rate)
- Possible association with myocardial infarction in patients with coronary heart disease
- Withdrawal symptoms of irritability, insomnia, low appetite, and anxiety, especially with chronic users

_____ (patient's initials)

Generalized Anxiety Disorder 7-Item (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by the following problems? (Please circle your response)	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	

Total Score (add your column scores) = _____

If you checked off any problems, please indicate how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer, RL, et. al., A brief measure for assessing generalized anxiety disorder, Archive of Internal Medicine, 2006:166, 1092-1097

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle your answers.	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For office coding:	_____	+ _____	+ _____	+ _____

Total Score: _____

If you checked off any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

_____ Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult

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DRUG ABUSE SCREENING TEST (DAST-10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the last 12 months.

"Drug Abuse" refers to: i) the use of prescribed or over-the-counter drugs in excess of their directions; and ii) any non-medical use of drugs.

The various classes of drugs may include cannabis, solvents, tranquilizers, barbiturates, cocaine, stimulants, hallucinogens or narcotics --- not alcoholic beverages.

Please circle the best response for every question unless you have answered no to Question 1.

	In the past 12 months…..		
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop abusing drugs (if you abuse them) when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your drug use?	Yes	No
7	Have you neglected your family because of your drug use?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use; i.e. memory loss, hepatitis, convulsions, bleeding?	Yes	No
	Scoring: Score 1 point for each question answered "Yes" Score: _____		

Score	Degree of Problems Related to Drug Use	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment