American Medical Evaluation Centers
Medical Marijuana Patient Registration/Questionnaire

Patient name: _____ **Sex**: M F **Date of Birth**: _____

Address: _____ **City, State, Zip**: _____

Home/Cell Phone: _____ **Social Security#**: _____ **Email Address**: _____

Marital Status: Single Married Widowed Separated Divorced

Occupation: _____

You are asking to be evaluated for the recommended use of Medical Marijuana. The following information **IS REQUIRED**. Please review the information carefully and be thorough in your answers.

Do you have a valid CA Resident ID, CA Driver's License, proof of CA residency, or CA issued Passport? ❒ Yes ❒ No

What medical conditions do you have that may require Medical Marijuana? Check all that apply and indicate severity for each condition with a numerical intensity (Low)1-2-3-4-5-6-7-8-9-10(High) if applicable.

❒ HIV	❒ Cancer	❒ Chronic Pain (Circle Severity) (Low)1-2-3-4-5-6-7-8-9-10(High)	❒ Headaches
❒ Chronic Insomnia	❒ Epilepsy (seizures)	❒ Asthma	❒ Hepatitis
❒ Nausea/Vomiting	❒ Arthralgias/Arthritis/Joint Disease	❒ Anorexia(Unwanted Appetite loss)	❒ Crohn's
❒ Glaucoma	❒ Spinal Disc Injury/Scoliosis	❒ Attention Deficit Disorder	❒ Anxiety
❒ Diabetes	❒ Myalgias/Other muscle Disease	❒ Obsessive-Compulsive Disorder	❒ Depression
❒ Endometriosis/PMS	❒ Colitis/GERD/Other GI disease	❒ Post-Traumatic Stress Disorder	❒ Schizophrenia
❒ Other:			

Current Medications: _____Allergies: _____

FEMALES ONLY: Are you currently pregnant? No ____ Yes ____
Are you currently breast feeding? No ____ Yes ____

Why are you requesting a recommendation for Medical Marijuana? Check all that apply:

❒ Prescription Medications not working ❒ Prescription Medications are chemical and not natural

❒ Side Effects of Prescription Medicines ❒ Prescription Medications can be addicting

- Name of Doctor/Clinic/Hospital who diagnosed your condition: _____
  (This can be from any state or country at any time in your life. The doctor can be any licensed medical doctor, surgeon, chiropractor, acupuncturist, or doctor of osteopathy)

- Address of Doctor/Clinic/Hospital: _____
  (If you do not know the exact address, the city and state will be sufficient.)

- Date of Last Visit with this Doctor/Clinic/Hospital: _____

- If you haven't seen a doctor for your medical condition, why not? _____

Are you currently on Federal probation? ____ or Federal parole? ____

How were you referred to us? How did you hear about us? _____

Patient Signature: _____ Date: _____

AMERICAN MEDICAL EVALUATION CENTERS
MEDICAL MARIJUANA CONSENT FORM

Medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions, which include:

- Cancer
- HIV (Human Immunodeficiency Virus) or AIDs
- Arthritis
- Glaucoma
- Migraine
- Anorexia
- Persistent muscle spasms
- Multiple sclerosis muscle spasms
- Cachexia (weight loss, wasting of muscle, loss of appetite, and general debility that can occur during a chronic disease)
- Severe or chronic pain
- Severe nausea.

Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:
"Substantially limit the ability of the person to conduct one or more major life activities, as defined in the Americans with Disabilities Act of 1990 (Public Law 101 ñ 336). If not alleviated, may cause serious harm to the patient's safety or physical or mental health."

The use of cannabis (medical marijuana) may affect coordination and cognition in ways that could impair your ability to drive, operate heavy machinery, or engage in potentially hazardous activities. Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer), and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. Cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to your health. Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in marijuana smoke.

Side effects of medical marijuana can include, but are not limited to:

- ❒ Pleasant change in mood/sensation
- ❒ Fatigue
- ❒ Confusion
- ❒ Dizziness
- ❒ Problem with memory
- ❒ Palpitations/fast heart beat
- ❒ Hunger
- ❒ Unpleasant change in mood/sensation
- ❒ Mental slowness
- ❒ Nervousness
- ❒ Cough
- ❒ Increased talkativeness
- ❒ Dry mouth
- ❒ Difficulty in completing complex tasks
- ❒ Impairment of motor skills, reaction time and physical coordination

Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include but are not limited to nausea, vomiting, disturbances to heart rhythm and numbness to the limbs, and hacking cough. For some patients, chronic marijuana can lead to laryngitis, bronchitis, and general apathy.

Some patients can become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms, while generally mild, can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite. Although marijuana does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in persons predisposed to that disorder. I understand that using marijuana while under the influence of alcohol is not recommended.

The cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities or contaminants.

Patient: _____ Date: _____

Witness: _____ Date: _____

American Medical Evaluation Centers
Medical Marijuana Patient Agreement

I agree to tell the attending physician if I ever had syndromes of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I ever been prescribed or taken medicine for any of these problems. I understand that the attending physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

If I start using medical marijuana, I agree to tell my attending physician if I start to feel sad or crying spells, loss my appetite, become unusually tired, lose interest in my usual activities, have changes in my normal sleep patterns, become more irritable than usual, withdraw from family and friends.

There are no known interactions between marijuana and medications or other herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements or other medications. Some users develop a tolerance to marijuana. This means higher and higher doses are required to achieve that same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician.

I understand that I am not to drive or operate heavy machinery while medicating with medical marijuana. And Medical Marijuana is not to be used within 1000 feet of any schoolyard, day care center, park grounds, playground, or anywhere else near children.

Should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use. I agree to discontinue its use and report any such problems or effects to the attending physician. I understand that the attending physician, staff, and representative of American Medical Evaluation Centers are not providing, dispensing or encouraging me to obtain medical marijuana. I have attempted to obtain medical records pertaining to my condition and currently have no further medical records pertaining to my condition.

Release of Liability

The physician, staff, and representative of American Medical Evaluation Centers are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care provider. The physician is only rendering an opinion regarding the therapeutic value of the use of medical marijuana. Furthermore, the undersigned, my heirs, assigns, or anymore acting on my behalf, hold the physician and his/her principles, agents or employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals in a result of my cannabis use.

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

Patient: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review it carefully.

USES AND DISCLOSURES

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, workers' compensation insurance, or from credit card companies that you may use to pay for services.

Health care operations - Your health information may be used as necessary to support the day-to-day activities and management from the offices American Medical Evaluation Centers.

Law enforcement - Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting - Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization - Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional uses of information

Appointment reminders - Your health information will be used by our staff to send you appointment reminders.

Information about treatments - Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

INDIVIDUAL RIGHTS - You have certain rights under the federal privacy standards. These include: the right to request restrictions on the use and disclosure of your protected health information; the right to receive confidential communications concerning your medical condition and treatment; the right to inspect and copy your protected health information; the right to amend or submit corrections to your protected health information; the right to receive an accounting of how and to whom your protected health information has been disclosed; the right to receive a printed copy of this notice.

DUTIES OF AMERICAN MEDICAL EVALUATION CENTERS - We are required by law to maintain the privacy of your health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRACTICES - As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Upon request, we will provide with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION - You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting my office staff. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office at:

American Medical Evaluation Centers
ATTN: Privacy Policies Department
21720 S. Vermont Ave., Ste. #103
Torrance, CA 90502

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practice adopted by the office of American Medical Evaluation Centers.

Signature_____ Date_____