MMP-MD PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex M F Social Security #: _____

Single Married Widowed Separated Divorced - Spouses Name: _____

Race: White African American American Indian Asian Hawaiian/Pacific Is. Declined

Ethnicity: Hispanic Non-Hispanic

In case of emergency whom should we notify?_____

Relation to Patient: _____ Daytime Phone # _____ Evening Phone # _____

GUARANTOR INFORMATION

Party Responsible: _____Relation to Patient: _____

Address: _____Phone #: _____
If different from Patient

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

I certify that the above information is complete and correct to the best of my knowledge.

Signature: _____ Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With my consent, Heights Medical may use and disclose protected health information (PHI) about me to carry out treatment, payment of healthcare operations (TPO). Refer to Heights Medical's Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. Heights Medical reserves the right to review its NPP at any time. NPP may be obtained at any time on line at the Heights Medical website or by requesting at the office.

With my consent, Heights Medical may mail, e-mail or call my home or other designated location and leave a message on voice mail or in person in reference to items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including lab results.

I have the right to request that Heights Medical restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to Heights Medical's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign the consent, Heights Medical may decline to provide treatment to me.

Document PR1-B

Acknowledgement of Receipt – Notice of Privacy Practices

I acknowledge that I have been provided the Notice of Privacy Practices (NPP) of Heights Medical Associates. The NPP tells me how Heights Medical Associates may use or disclose my Protected Health Information (PHI) and about my rights and the legal duties of Heights Medical Associates regarding my PHI.

I understand that if I have any questions the NPP provides me with the name or title and telephone number of a person or office to contact for further information.

Date: _____

Individual Name: Print_____

Sign_____

Date of Birth: _____ **Social Security #** _____

Identity of the Individual verified, Documentation on file.

Employee Initials_____

Signature of Individual or Personal Representative _____

Printed Name of Personal Representative, if any _____

Personal Representative Authority to Act for the Individual _____
(Documentation may be requested)

Identity and Authority to Act of Personal Representative verified, Documentation on file confirmed by Representative.

_____

Signature Printed Name

Or

Made a good faith effort to obtain a written acknowledgment of the NPP but was unable to because:

_____

_____

Representative:

_____

Signature Printed Name

Acknowledgements, Agreements, Disclosures and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree to each item. By initialing, you understand and agree to the information disclosed. If you have questions or do not understand the information below, consult with the attending physician before initializing or signing this agreement. Please do not sign this agreement and do not use marijuana if you do not understand the information you have received.

Medical marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use any medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio. This is a direct violation of HIPPA regulations and patient/doctor confidentiality. I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize Dr. Bellavia to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient. I understand that the attending physician cannot guarantee that the state program of NJ will issue a medical marijuana card. It will be the decision of the physician only whether the patient is recommended to the state program or not.

I, _____, (Patient's Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: Cancer, HIV, Nausea, Arthritis, Chronic Pain, Glaucoma, Cachexia, Migraines, Anorexia, Seizures and persistent muscle spasms. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limits the ability of the person to conduct one or more major life activities as defined in the American with Disabilities Act of 1990 (Public Law 101-336)
- Other conditions for which marijuana provides relief
- If not alleviated, may cause harm to the patient's safety or physical or mental health

Patient agrees by initialing the following:

____ I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery, drive or engage in potentially hazardous activities.

____ I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia psychotic symptoms and overeating.

____ I understand that some patients become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms can include: feeling of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

____ I understand that chronic use of medical marijuana can lead to laryngitis, bronchitis and general apathy.

____ I understand that although marijuana does not produce a specific psychosis, the possibilities exists that it may exacerbate schizophrenia in persons predisposed to that disorder.

____ I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition.

____ I understand there are few known interactions between marijuana and medications other than 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.

____ I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of Marijuana as a drug. I understand the significance of this fact.

____ I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

____ I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

____ I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

____ I understand should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report any such problems or effects to the attending physician. 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 cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers in the lungs, mouth and tongue. I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. I understand that there are many methods of intake that substantially reduce the harmful effects of smoking such as vaporizers, edibles, drops, etc.

____ I understand 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 system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, disturbances to heart rhythms, numbness in the limbs, anxiety attacks and incapacitation.

____ If I start taking medical marijuana, I agree to tell my attending physician if I: start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends or any other side effect that is not to your liking.

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____ I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

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

____ I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

____ Medical Marijuana is not regulated by the USFDA and therefor may contain unknown quantities of active ingredients, impurities and/or contaminants.

____ I am not permitted to smoke within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

____ I agree to follow up with the attending physician with supporting medical records pertaining to my medical conditions.

____ I understand the attending physician and/or staff are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician and/or staff will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

____ I certify that I have read this document and declare under penalty of perjury that the information contained herein is true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form, the letter of recommendation will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, Dr. Bellavia will report any of the above mentioned activities to the appropriate local authorities.

____ The physician and staff are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on my behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

Patient Name: _____
Please Print

Patient Signature: _____

Date: _____

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