

Fax: 727-685-1833

Office: 727-440-7786

Authorization, Fees, and Office Policy

Authorization for Treatment

I hereby authorize the staff of Compassionate Care Clinics of Pinellas to render medical services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that all charges are to be paid at the time services are rendered and that insurance or Medicare are **not** accepted for these services.

Financial Agreement

I understand that I am financially responsible for services rendered by physicians employed by Compassionate Care Clinics of Pinellas and their staff. I have been advised of the fees relating to my consultation as well as acceptable forms of payment prior to seeing the physician. I understand that insurance or Medicare are **not** accepted for cannabis evaluations.

Office Policy

- Please discuss all financial matters with office staff or the Office Manager, not the Medical Practitioners. Their time is limited to medical concerns only.
- If you must cancel an appointment, we require 48-hour notice unless there is a mutually agreed upon emergency. If you do not keep 2 appointments (no call/no show) in a row, you will be discharged from this practice. We reserve the right to charge a \$25 fee for any appointments that were cancelled without notice.
- All patients must print name on sign in sheet upon arrival to assure that they will be acknowledged as being present for their scheduled appointment.
- Should the physician be unable to recommend cannabis treatment, you will be refunded your fees prior to leaving our office.

I agree to all the terms above.	I understand that	by signing I am	acknowledging t	that I will be	e held
responsible for the agreements a	bove.				
-					

Patient/Guardian Signature]	Date		



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Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can gain access to this information.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment
- Payment
- Health care operations

You Have a Right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any restricted restriction
- Receive confidential communications from us, upon written request
- Inspect and request copies of your medical information, upon written request
- Request to amend incorrect or incomplete medical information, upon written request
- Receive an accounting of any disclosures made, upon written request

We are Responsible for:

- Maintaining the privacy of your medical information
- Abiding by the terms of this notice
- Providing written notice of any changes to this notice

Authorizations:

Upon your written authorization (verbal or implied in event of an emergency), we may disclose your medical information to a requesting entity, such as another provider, a relative, or a caretaker. You may revoke any authorization you make at any time, except to the extent that is was already relied on.

Patient Contact:

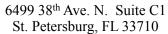
We may contact you by telephone, mail, or e-mail to provide such information as appointment reminders, treatment information, or any other necessary communications.

Complaints:

You may complain to us or to the Department of Health and Human Services if you believe that your privacy has been violated. If you wish to complain to us, please provide the office manager with written notice if you believe your privacy has been violated. All notices received will be investigated and reviewed by a compliance officer. To obtain information, contact our Office Manager at 727-440-7786.

I have reviewed the "Notice of Privacy Practices" from Compassionate Care Clinics of Pinellas.	I
understand a copy will be provided upon request.	

Patient/Guardian Signature	Date	



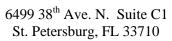


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Medical Records Release Authorization

Release From:	
Physician/Facility:	
Address:	
Phone #:	
Fax #:	
Patient Name:	Date of Birth:
Patient Phone:	
Today's Date: Aut	horization Expires:
Information to be disclosed:	
All RecordsImaging ReportsLabs	_Prescriptions/Medications
Operative reportsConsultation reportsP	rogress Notes
Other:	
Purpose for Disclosure:	
Release records to: Compassionate Care Clinical	
6499 38th Ave. N. Su	ite C1
St. Petersburg, FL 3	33710
Fax to: 727-685-18	833
Authorization : I certify that this request has been made fre given above is accurate and complete to the best of my knowled copy of this form after I sign it. I may revoke this authorization action has already been taken to comply with it. Written revocation understand that the protected health information may include me status, diagnostic and treatment records.	ge. I understand I have the right to receive a in writing at any time except to the extent that tion is effective upon receipt at our facility. I
Patient Signature:	Date:

Confidentiality Notice: The contents of this facsimile belong to Compassionate Care Clinics of Pinellas and may be privileged, confidential, or otherwise protected from disclosure. The information is intended for the addressee only who is prohibited from disclosing this information to any party and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, any disclosure, copy distribution or action taken in reliance to the contents of this facsimile is strictly prohibited.





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New Patient Demographics

Name:		Date of Birth:			
(Last)	(First)	(MI)		Ionth/Day/Year)	
Mailing Address:					
(Stre	et/Apt.)	(City)	(State)	(Zip Code)	
Phone #:		* E-mail address:			
Driver's License #:		Social Sec	curity #:		
	If female, are you pregnar / Married / Widowed / Div				
Children: Y / N	How many:		Ages:		
Do you use tobacco?	Y / N How much:		How many years:	·	
Do you drink alcohol?	Y / N How much:		How often:		
Reason for cannabis tre	eatment? (If condition is n apply:	ot listed please select of	her medical condition :	and explain.)	
Cancer	Epilepsy		Glaucoma		
PTSD	HIV/AID	S	ALS (Lou Gehrig	g's Disease)	
Crohn's Disease	Parkinson	n's Disease	Multiple Sclerosi	s	
Other medical co	ondition of like kind or clas	s with symptoms compar	rable to those listed above	ve.	
Explain (if other):					
Diagnosing Physician o	or Specialist:		Phone #:		

^{*}E-mail address must be provided. Communication from the Medical Marijuana Use registry will come by e-mail.

Name: Date of Birth:

Previous Medical History

Please list all symptoms you experience, frequency, severity, and duration:

(Ex: muscle spasms, severe nausea, vomiting, anxiety, depression, panic attacks, chest pain, loss of appetite, insomnia, abdominal pain, exhaustion, restlessness, fatigue, constipation, nerve pain, back pain, severe menstrual cramps, loss of motor control, tremors or shaking of arms and limbs, dizziness, fainting, unstable mood, speech difficulty, etc...)

Symptom	Frequency (How (Severity (1-10)	Duration (How to
<u>Treatment</u>	<u>Duration</u>	<u>Outcome</u>	
	ons to include name of medic	-	
Medication	<u>Dose</u>	Frequency	

Name:	Date of Birth:
variic.	Date of Ditti.

Previous Medical History

Please list any previous hospitalizations in the past 24 months:

Reason	<u>Date</u>
ease list any previous surgery or procedures done	e in the past 24 months:
Reason	<u>Date</u>
request that medical information, test results, or n	nessages:
nitial all below that apply)	
Be given to me directly in person or over the	
Be left on my home/cell answering machine of	
Be left with a member of my household. Nar	ne:
	f my knowledge. I have not made any false statements or understand that I am financially responsible for all charges incurre
atient/Guardian Signature	

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB nu

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.				
O: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health are facility) PATIENT NAME (Last, First, Middle Initial)				
Department of Veterans Affairs				
Location:	SOCIAL SECURITY NUMBER			
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHO	OM INFORMATION IS TO BE RELEAS	SED		
Compassionate Care Clinics of Pinellas 6499 38th Ave. N. Suite	C1, St. Petersburg, FI 337	10		
VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s): X DRUG ABUSE X ALCOHOLISM OR ALCOHOL ABUSE X TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) X SICKLE CELL ANEMIA				
INFORMATION REQUESTED (Check applicable box(es) and state that approximate dates covered by each) COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT				
Pertinent health information from health records of the last 12 months including information created within 24 months after the signature date of this authorization.				
PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL T	O WHOM INFORMATION IS TO BE F	RELEASED		
Certification				
NOTE: ADDITIONAL ITEMS OF INFORMATION				
AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):				
Two years from date of signature				
I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.				
DATE (mm/dd/yyyy) SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)				
FOR VA USE ONLY				
IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL	RELEASED		
	DATE RELEASED	RELEASED BY		