COMPASSIONATE CARE CLINICS OF PINELLAS

6499 38th Ave. N. Suite C1
St. Petersburg, FL 33710

Office: 727-440-7786
Fax: 727-685-1833

# 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 that I will be held responsible for the agreements above.**

_____ _____

**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: _____ Authorization Expires: _____

Information to be disclosed:

___All Records ___Imaging Reports ___Labs ___Prescriptions/Medications

___Operative reports ___Consultation reports ___Progress Notes

___Other: _____

Purpose for Disclosure: _____

Release records to: **Compassionate Care Clinics of Pinellas**

**6499 38th Ave. N. Suite C1**

**St. Petersburg, FL 33710**

**Fax to: 727-685-1833**

**Authorization**: I certify that this request has been made freely and voluntarily and that the information given above is accurate and complete to the best of my knowledge. I understand I have the right to 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 at our facility. I understand that the protected health information may include mental health, drug and alcohol abuse, HIV/AIDS status, diagnostic and treatment records.

**Patient Signature**: _____**Date**: _____

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## New Patient Demographics

Name: _____ Date of Birth: _____
**(Last) (First) (MI) (Month/Day/Year)**

Mailing Address: _____
**(Street/Apt.) (City) (State) (Zip Code)**

Phone #: _____ * E-mail address: _____

Driver's License #: _____ Social Security #: _____

**Please circle one:**
Gender: M / F If female, are you pregnant or at risk of becoming pregnant? Y / N

Marital Status: Single / Married / Widowed / Divorced Spouses Name: _____

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 treatment? **(If condition is not listed please select other medical condition and explain.)**
**Please check any that apply:**

Cancer _____ Epilepsy _____ Glaucoma _____

PTSD _____ HIV/AIDS _____ ALS (Lou Gehrig's Disease) _____

Crohn's Disease _____ Parkinson's Disease _____ Multiple Sclerosis _____

_____ Other medical condition of like kind or class with symptoms comparable to those listed above.

Explain (if other):

_____

_____

Diagnosing Physician 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 often?) | Severity (1-10) | Duration (How long?) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**Please list all treatments you have tried, how long each treatment was attempted, and the outcomes of each treatment:**

| | Treatment | Duration | Outcome |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**Please list all current medications to include name of medication, dose, and frequency:**

| | Medication | Dose | Frequency |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

Name: Date of Birth:

## Previous Medical History

**Please list any previous hospitalizations in the past 24 months:**

| | Reason | Date |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**Please list any previous surgery or procedures done in the past 24 months:**

| | Reason | Date |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**I request that medical information, test results, or messages:**
**(Initial all below that apply)**

_____ Be given to me directly in person or over the phone.
_____ Be left on my home/cell answering machine or voicemail.
_____ Be left with a member of my household. Name: _____

The above information is true and correct to the best of my knowledge. I have not made any false statements or misrepresentations. I consent to medical treatment. I understand that I am financially responsible for all charges incurred and required to pay when services are rendered.

_____ _____

**Patient/Guardian Signature** **Date**

*OMB Number: 2900-0260*
*Estimated Burden: 2 minutes*

# 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 number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

Department of Veterans Affairs
Location:

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Compassionate Care Clinics of Pinellas 6499 38th Ave. N. Suite C1, St. Petersburg, Fl 33710

**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 the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

[ ] COPY OF HOSPITAL SUMMARY [ ] COPY OF OUTPATIENT TREATMENT NOTE(S) [X] OTHER (Specify)

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 TO WHOM INFORMATION IS TO BE RELEASED

Certification

**NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM**

**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