Aysev - Comprehensive Canabanoid Care
5341 West Atlantic Ave #301
Delray Beach, FL 33484
Office: 561-570-5500 - Fax (561) 450-9934

New Patient Packet

How would you like us to address you? ____
[ ] Just use my Drivers Licence Info - it's correct
Full Legal Name (First) (Middle) (Last) ____
Address Apt. No. City State Zip ____
Date of Birth: ______________________
***E-mail:** ________________________ **SSN#** ________________________________
Current Weight____________________
Email address with which you want the State of Florida to communicate with you

Cell: ___________________________ Home: ________________________________

Spouse Name: _____________________________
With whom may we discuss your medical care/needs: [ ] No-One
____

Do You have a Sense of Humor? ____

\- -

Who Referred you to us? ____

What is the main reason that you feel that medical Marijuana will help you?
____
____
____

What have you tried already? ____
____
____
____

I understand that the initial assessments does NOT guarantee that you will be approved for Medical Marijuana, low THC marijuana, or any similar medical product.

Signature _________________________________ Date:___________________

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Medical Problems (including present conditions):

Diagnosis	Date started	Diagnosis	Date started

Have you ever had/Currently have?

Cancer: (type) _____

Hypertension	Spinal Stenosis	Cholesterol Issues	Headaches
Diabetes	Acid Reflux	Thyroid Issues	Foot Problems
Heart Attack	a Stroke	Kidney Problems	Arthritis
Atrial Fibrillation	COPD/Asthma	Liver Problems	STDs

What other Specialist/Doctors/Health Care providers do you see:

Name	Specialty	Contact info

CURRENT PRESCRIPTION MEDICINES

Medicine	Dose	How Often	Treating what?

OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take:

Medicine	Dose	How Often	Treating what?

Allergies:

To What	Reaction:	To What	Reaction:

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Have you Ever Had Surgery?

Procedure	When?	Where?	Name of Surgeon?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for anything else? [ ] Yes [ ] No
_____
_____

Social History:
Single/Married/Divorced/Widowed? _____
Children? _____
Who do you live with? _____

Were you ever a smoker? _____When did you Quit?_____Paks/Day_____# years_____
if current Smoker - how many times have you tried to quit? _____
Were you ever a Drinker? _____When did you Quit?_____Drinks/Day____# years_____
Have you ever used:
Cocaine Heroin Marijuana Extacy Mushrooms LSD Other_____

Females:
[ ] Menopause Age _____ [ ] Still having Periods
Last PAP_____ Last Mammo _____ GYN: _____
Pregnancies_____ G ____ P____ _____ _____ _____

Preventative Medicine:
tetanus shot _____ flu shot _____ pneumonia vaccine _____
Shingles Vaccine _____ hepatitis vaccine _____ TB test _____
Colonoscopy _____ chest x-ray _____ EKG_____

Family History:

	Alive?	Age?	Medical Problems	Heart attack or Stroke before age 55?
Mother				
Father				
Sib #1				
Sib #2				

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Date of Birth: _____
Phone Number: _____

I respectfully authorize and request that you release copies of my medical records to: Aysev LLC. I authorize release of information of my medical record: I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative) _____ Date: _____
Relationship to Patient: [ ] Self [ ] Guardian [ ] Power of Attorney
Witness: _____ Date: _____

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Office Policies

Scheduling:

We will do our best to be on time, we can only ask the same of you. We generally wont charge a fee for changing appointment, we get it, things happen, however - if we see a pattern where appointments are constantly being changed and/or missed we may need to institute individual patient fees. We will not charge someone with out letting them know before.

We attempt to contact you/your designated other to remind you of your up-coming appointment; however, it is the responsibility of the patient to arrive for their appointment on time.

Signature _____

Fees:

Just like you can't go into a supermarket and ask to purchase food and ask them to pay them another time. Fees, Co-pays and forward balances are due on the day of service.

- If an account is not paid in full within 90 days, a 25% collection processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing.
- No additional appointments will be made for delinquent accounts until they are brought current. Checks returned for any reason will be assessed a $40.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

Signature _____

I understand that while Medical Marijuana/Cannabis is available in Florida, it remains illegal under federal law.

Signature _____ Date _____

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Consent #1

Section 381.986, F.S. requires physicians obtain voluntary, written informed consent from the patient, or the patient's legal representative, to treatment with low-THC cannabis after sufficiently explaining:

- The current state of knowledge in the medical community of the effectiveness of treatment of the patient's condition with low-THC cannabis;
    - This [was/was not] Reviewed in person

- The medically acceptable alternatives;
    - _____
    - _____
    - Living with the current situation

- The potential risks and side effects.
- Somnolence
- Short-term memory problems
- Severe anxiety, including fear that one is being watched or followed (paranoia)
- Very strange behavior, seeing, hearing or smelling things that aren't there, not being able to tell imagination from reality (psychosis)
- Panic
- Hallucinations
- Loss of sense of personal identity
- Lowered reaction time
- Increased heart rate (risk of heart attack), Lower Blood Pressure (Orthostatic Hypotension)
- Increased risk of stroke
- Problems with coordination (impairing safe driving or playing sports)
- Sexual dysfunction
- Impaired thinking and ability to learn and perform complex tasks
- Other possible negative effects

Name: _____ Signature: _____
Date: _____ Physician: _____

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(Consent #2)

For terminal patients ordered cannabis pursuant to section 381.96, F.S. and section 499.0295, F.S., Florida law requires physicians must obtain written informed consent as defined in section 499.0295, F.S. from the patient, or the patient's legal representative, to treatment with medical cannabis. This consent must include:

- I have received an explanation that the currently approved products and treatments for the patient's terminal condition.
- I concurs with my physician physician in believing that all currently approved products and treatments are unlikely to prolong the patient's life.
- Identification of the specific investigational drug/device: (Marijuana/Cannabis/THC/CBD).
- We have reviewed a realistic description of the most likely outcomes of using specific investigational drug/device(Marijuana/Cannabis/THC/CBD) This includes the possibility that new, unanticipated, different, or worse symptoms might result and death could be hastened by the proposed treatment.
- I understand that the patient's health plan or third-party administrator and physician are not obligated to pay for care or treatment consequent to the use of the investigational drug, biological product, or device unless required to do so by law or contract.
- I understand that the patient's eligibility for hospice care may be withdrawn if the patient begins treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if the treatment ends and the patient meets hospice eligibility requirements.
- I understands that I am liable for all expenses consequent to the use of the investigational drug, biological product, or device and that liability extends to the patient's estate, unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

Name: _____ Signature: _____
Date: _____ Physician: _____

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HIPPA

Your Rights:

Patient Rights Regarding Medical Records *All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms which will be provided upon request. All changes to preferred forms of communication must also be made in writing. You have the following rights regarding health information we maintain about you: Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review. Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that: • Was not created by us, unless the person or entity that created the information is no longer available to make the amendment • Is not part of the health information kept by or for our practice • Is not part of the information that you would be permitted to inspect and copy • Is accurate and complete Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified. Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you. Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any staff member. Changes to This Notice We reserve the right to change this notice and apply it to any past, present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy of our most current notice at any time. Complaints If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. Other Uses of Health Information Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. You have the right to revoke this permission for any health information that has not yet been shared.

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PLEASE REVIEW CAREFULLY. Our Pledge Regarding Health Information The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI). We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI. We are required by law to: • Make sure that health information that identifies you is kept private • Give you this notice of our legal duties and privacy practices with respect to your PHI • Follow the terms of the notice that is currently in effect How We May Use and Disclose Your PHI The following categories describe different ways that we use and disclose health information. For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you. For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment.. Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you. As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law. Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s). Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following: • Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls. Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

Signature _____ Date: _____