NATURAHEALTH
Integrative Medical Center, LLC

5055 W. Ray Road Suite 21
Chandler, AZ 85226
Phone (480) 634-5596
Fax (480) 636-7920

PATIENT CONTACT

Name:_____DOB:_____Age:_____

Address:_____

City:_____County: _____State:_____Zip:_____

Phone Number:_____ May we leave a message? _____

Email (For your APPROVAL from the state):_____

Please list your condition/concerns, including onset:

_____

Please list the treatments you have tried or have been prescribed (medications, physical therapy, surgery, chiropractic, injections, etc.):

_____

Have you ever been diagnosed with a mental illness? If yes, are currently being treated for it?

_____

If you are female is the following statement true?
I am NOT currently pregnant OR breastfeeding OR suspect that I am. INITIAL _____

POTENTIAL RISKS/BENEFITS OF MEDICAL MARIJUANA

Potential Risks:
*Potential for abuse
*Sedation
*Blood shot eyes
*Coughing
*Increased appetite
*Lowers blood pressure
*Bronchitis
*Temporary mental confusion
*Panic reactions
*Hallucinations
*Impaired coordination, cognition
*Impair ability to operate any machinery including a vehicle
*Marijuana has the risks of contaminates such as, bacteria, fungi, molds, pesticides, herbicides, insects, fungicides
*Smoking marijuana may increase the risk of asthma, COPD, emphysema, and certain cancers
*Use of marijuana may exacerbate symptoms of schizophrenia

Potential Benefits:
*Anti-inflammatory
*Pain reduction
*Anti-nausea

Symptoms of Withdrawal:
*Nausea, vomiting, cough, depression, irritability, insomnia, sleep disturbances, fatigue, appetite loss

*Use of marijuana in conjunction with alcohol, illegal substances, certain prescribed medications, and while operating any vehicle is not recommended

NATURAHEALT Integrative Medical Center, LLC is NOT a dispensary. Any illegal substances are not allowed on its property.
I have read the above information and fully understand the RISKS AND BENEFITS of Medicinal Marijuana.

_____
INITIALS

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PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain Payment form third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by NATURAHEALTH Integrative Medical Center (NHIMC) of our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact NHIMC to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand NHIMC is not required to agree to my requested restrictions, but if NHIMC does agree then they are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that NHIMC has taken action relying on this consent.

I acknowledge that I have read and understand all the foregoing information. Please initial below.

_____
INITIALS

INFORMED CONSENT and RELEASE OF LIABILITY FORM

I understand that a licensed physician recommendation that I may benefit from the use of medical marijuana does not guarantee that its use will help my qualifying condition. I release NATURAHEALTH Integrative Medical Center, LLC and all affiliates (physicians, staff members, officers, investors, etc.) from all liability resulting in my use, possession, or the denial of my application for medical marijuana for any reason.

I also understand that any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now, in the future, or from another licensed health care provider.

I understand that I am currently under “self care.” The physicians at NHIMC are in no way establishing themselves as my primary care physician, unless stated otherwise.

I agree to notify the physician on staff if I have been prescribed or am taking any supplements, herbs, or prescription medication for the condition. Have ever had suicidal symptoms or thoughts. Been diagnosed with a mental illness or experienced depression/ psychosis.

I acknowledge that while I may lawfully purchase, possess and use medical marijuana under state law, it is lawful only if done in strict compliance with the requirements of the State Medical Marijuana Act, Arizona Revised Statutes Tiles 36, Chapter 28.1 and Arizona Administrative Code Title 9, Chapter 17. Any failure to comply with the Act may result in the revocation of the registry identification card or registration certificate issued by the Arizona Department of Health Services, and possible arrest, prosecution, imprisonment and fines for violation of state drug laws. I have read and reviewed the Arizona Department of Health Services website at www.azdhs.gov/medicalmarijuana and understand all rules and regulations involved with the program.

I acknowledge that I have read and understand all the foregoing information and I also understand that the ultimate responsibility for my health is my own.

_____
INITIALS

I acknowledge that I have read and understand the information provided and that the above information is true and correct to the best of my knowledge. I certify that I am a competent adult of at least 18 years of age.

_____ _____ _____
Signature **Print Name** **Date**