NEW PATIENT INTAKE PACKET

Medical Marijuana

Thank you for your interest in our medical practice. During your first visit, you'll be required to supply us with a valid Maryland driver's license or state ID card. If you do not possess a valid Maryland driver license or Maryland identification card or you may submit a copy of your Maryland voter registration card.

To streamline your initial appointment, we ask that you read, and complete each form within this packet prior to your scheduled visit.

We will need to review your most current medical records from the last 12 months or copies of medical records that support your diagnosis. You can ask your current primary care physician or specialist to fax or mail us a copy of your records. Our fax number is 410-820-0668.
or

You can complete our medical records release form included within this packet and give it to your current doctor. (Note that your doctor's office may charge you to send us records.)

If you have any questions or concerns, please call us at 410-820-6870.

Initial office visit is $200. Follow up visit is $100. Payment is due at the date of service. Medical Marijuana evaluation is not a medically covered service by health insurance and cannot be billed.

Payment of this fee does not guarantee qualification/ eligibility of a medical marijuana certificate. I understand that the fee is for determination of medical necessity.

Cancellation/No Show Payment Policy

There is a $50 charge for a missed appointment or cancelled less than 24 hours prior to visit.

The State of Maryland mandates routine follow up appointments and an ongoing relationship. Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider.

We request you come 15 minutes early to your appointment to complete the required paperwork. If you are 15 minutes past your scheduled time, your appointment may be cancelled. Multiple missed appointments may result in dismissal from the practice.

Signature: _____ Date: _____

Consent for Release of Medical Information

Anne L. Grady, D.O.P.A.
8221 Teal Drive, Suite 204
Easton, Md. 21601
410-820-6870
410-820-0668 fax

Patient Information and Attestation

Patient Name:_____ Today's Date: _____

Birth Date: _____ Social Security # _____

Patient Street Address: _____

City: _____ State: _____ Zip Code_____

Release Records to Physician/ Hospital/ Insurance Company/ Individual:

Anne L. Grady, D.O
Address: 8221 Teal Drive Suite 204
Easton, Maryland 21601
Telephone: 410-820-6870
Fax: 410-820-0668

Obtain Records from Physician/Hospital/ Insurance Company:

_____

Address:_____

Telephone:_____ Fax:_____

Purpose for release: ___ Communication purposes only. This is not a transfer of care.

Information to be released:

I consent to release information regarding alcoholism and drug abuse. _____ (Initials)

I consent to release information regarding mental disorders and rehabilitation. _____ (Initials)

I consent to release information regarding HlV, AIDS, & sexually transmitted diseases. _____ (Initials)

I consent to release information regarding lab studies, EKG's, and from consulting specialists. _____ (Initials)

The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected under the federal law.

Signature: _____ Date: _____

Patient Declaration

I. _____(insert name)

am requesting an evaluation and consideration for medical marijuana. I have the following medical problem(s) that may qualify me for medical marijuana treatment. (Check one or more if applicable.)

_____ a chronic or debilitating disease or medical condition that results in being admitted into hospice or receiving palliative care.

_____a chronic or debilitating disease or medical condition that causes:

_____cachexia

_____anorexia

_____ wasting syndrome

_____ severe or chronic pain

_____ severe nausea

_____ seizures

_____ severe or persistent muscle spasms

_____ glaucoma

_____post-traumatic stress disorder (PTSD)

_____ or another chronic medical condition which is severe and for which other treatments have been ineffective. Specify _____

_____ hospice / palliative care

My symptoms are severe and I have been treated with other medical treatments that have been ineffective. I understand it is my responsibility to provide documentation of my medical problem(s) through medical records, an interview and agree to submit to a physical exam if required.

Signature:_____ Date: _____

Printed Name:_____DOB_____
First Middle Last

_____
Address City State Zip Code

Phone:_____ Cell:_____

Marijuana Acknowledgement of Disclosure

The effects of Medical Marijuana may vary widely depending on the strain and ingestion method. If Medical Marijuana is vaporized or smoked: it may be hazardous to your health. Medical Marijuana contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease. If Medical Marijuana is eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more and effects may last up to several days. There is limited information on the side effects of using Medical Marijuana, and there may be associated health risks. Symptoms of Medical Marijuana overdose include nausea, vomiting and disturbances to heart rhythm. For some patients, chronic Medical Marijuana usage can lead to laryngitis, bronchitis, and general apathy.

I understand side effects of Medical Marijuana can include but are not limited to: Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, Poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation.

The scientific basis for the medical use of Medical Marijuana is not complete. There is little known regarding how Medical Marijuana may, or may not, react with other pharmaceutical or herbal medications. Some patients can become dependent on Medical Marijuana. This means they experience withdrawal symptoms when they stop using Medical Marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite. Some users develop a tolerance to Medical Marijuana. This means higher and higher doses are required to achieve the same symptom relief.

The possibility exists that Medical Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. Women should not consume Medical Marijuana while planning to become pregnant, during pregnancy, or while breast feeding, Using Medical Marijuana while under the influence of alcohol is not recommended. The use of Medical Marijuana may affect coordination, cognition, and judgment. While under the influence of Medical Marijuana, do not to drive, operate machinery, or engage in potentially hazardous activities.

Always keep Medical Marijuana out of reach of children and pets. Keep Medical Marijuana in a lock box or secure place.

_____ _____

Signature Date

Printed Name:_____DOB_____

First Middle Last

Name_____ Date of Birth___/____/_____ Date ____/____/_____

Reason for Medical Marijuana request:

1._____

2._____

Hospitalizations or Surgeries

Hospitalization/ Surgery	Date	Reason	Surgeon	Hospital

Medications (list all medications, dose and frequency per day)

1	**6**
2	**7**
3	**8**
4	**9**
5	**10**

Allergies

Medication, Food, Environmental	Reason	Date

Vaccinations-

Do you have a list of your vaccinations?_____ Are you up to date with vaccinations? _____

Have you had any adverse reactions to any vaccination?_____

Name_____ Date of Birth___/____/_____ Date ____/____/_____

Your Medical/Family History (check box)

	Yourself	Father	Mother	Siblings B-brother S-Sister	Father's Parents Grandfather	Father's Parents Grandmother	Mother's Parents Grandfather	Mother's Parents Grandmother
Age (or age at time of Death)								
Alive								
Cause of death								
Alcoholism								
Asthma								
Bleeding Disorder								
Cancer (specify)								
Diabetes (type)								
Epilepsy /Convulsion								
Glaucoma								
Heart Disease								
High Blood Pressure / Hypertension								
Kidney Disease								
Mental Illness (specify)								
Migraine								
Osteoporosis								
Thyroid Disease								
Other _____								
Other _____								

Patient Information

Please Print Clearly & Complete All Information **Office Use Only**

Name (First, Middle Initial, Last) **Date of OfficeVisit/Initial**

____

Address:_________________________________**P.O. Box:**__________

City:________________________**State:**________**Zip Code:**_________

Date of Birth:_______________**Age:**_____**Sex:Male/Female**______

Marital Status:S-M-W-D Social Security#:______________________

Home Phone # ___________________**Work Phone #**______________

e-mail address ____

Employer____

Employer Phone ____

Circle One: **Employed Full-time/ Employed Part-time/ Retired**
Full-time Student/ Part-time Student

Emergency Contact

Name:____

Address:____

Phone# __________________________**Relationship**____________

Notice of Privacy Practices:

I hereby assign, transfer, and set over to Dr. Anne L. Grady, D.O., P.A. all my rights, title, and interest to my Protected Health Information (PHI) to obtain treatment, payment, and healthcare or for operational purposes such as quality assurance. I authorize the release of any medical information to determine these benefits.

I understand that I am financially responsible for all charges whether or not they are covered by my insurance, and will notify Dr. Anne Grady, D.O.,P.A. of any change in my health insurance. Also, I have the right and obligation to correct any information which may materially differ from those set forth here initially.

I understand that Dr. Grady is legally bound to limit my PHI and a 'Consent for Release of Medical Information' form is a requirement for the disclosure of my PHI to other parties. I also understand that there are legitimate uses and disclosures which consent, or authorization, or opportunity to agree or object is not required. Such non-routine requests will be approved by Dr. Grady solely.

I promise to promptly notify Dr. Anne L. Grady, D.O., P.A. if there is any material change in my health or those of my dependents. Furthermore, I understand that I will have reasonable access to my medical records under the terms and conditions set forth by Dr. Grady, D.O., P.A. I also give permission for myself and/or my dependents (minor under the age of 18) to be treated for any medical problems while under the care of Dr. Grady and/or any designates. This authorization shall remain valid until written notice is given by me or my representative revoking said authorization.

Signature Date Witness initial

Name_____ Date of Birth___/____/_____ Date ____/____/_____

Social History

Employment type - Employed / Unemployed/ Student/ Retired Profession-_____

Marital Status Single/ Married/ Divorced/ Widowed

Number of children

Sexual History not sexually active/ sexually active homosexual/ heterosexual/ bisexual multiple partners high risk behavior

Exercise none rarely daily weekly type of activity_____

Smoking- never smoked current smoker former smoker (year_____) <1ppd 1-2ppd 2-3ppd > Secondhand smoker

Tobacco use cessation counseling- are you interested in stopping? Yes no

Illicit drug use yes no

Alcohol Use none rare 1-2 drinks / week 3-6 drinks/ week Daily Occasionally

Caffeine intake none rarely daily many times per day coffee/ tea soda other caffeine_____

Preferred Language _____

Race _____

Ethnicity _____

Previous Primary Care Physician _____

Date of last office visit with primary care physician _____

Primary Insurance _____

Secondary Insurance _____