SUN VALLEY MMJ
CERTIFICATION CLINIC

PATIENT INTAKE FORM

NAME: _____ DATE OF BIRTH _____
LAST FIRST MIDDLE

ADDRESS: _____
ADDRESS APT # CITY STATE ZIP

PHONE: _____ EMAIL: _____

CAN WE LEAVE A MESSAGE ON YOUR PHONE: ☐ YES ☐ NO DO WE HAVE YOUR PERMISSION TO EMAIL YOU (APPOINTMENT INFORMATION AND SPECIALS)? ☐ YES ☐ NO

HOW DID YOU LEARN ABOUT US? _____

ARE YOU A VETERAN? ☐ YES ☐ NO
DO YOU RECEIVE SUPPLEMENTAL NUTRITIONAL ASSISTANCE? ☐ YES ☐ NO
ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? ☐ YES ☐ NO
ARE YOU RENEWING A CURRENT ARIZONA MEDICAL MARIJUANA CARD? ☐ YES ☐ NO
ARE YOU A PREVIOUS PATIENT OF OURS? ☐ YES ☐ NO

PLEASE LIST THE PRIMARY HEALTH PROBLEMS THAT HAVE BROUGHT YOU HERE TODAY:

COMPLAINT 1: _____ DATE SYMPTOMS BEGAN: _____

COMPLAINT 2: _____ DATE SYMPTOMS BEGAN: _____

HAVE YOU BEEN MEDICALLY TREATED IN ANOTHER STATE WITHIN THE LAST YEAR? ☐ NO ☐ YES IF YES, WHERE: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN.

CHRONIC PAIN? ☐ YES ☐ NO _____
MUSCLE SPASMS? ☐ YES ☐ NO _____
NAUSEA? ☐ YES ☐ NO _____

HAVE YOU EXPERIENCED ANY DIFFICULTIES WITH THE FOLLOWING?

FREQUENT HEADACHES	☐ YES ☐ NO	HIV/ AIDS	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO
MIGRAINES	☐ YES ☐ NO	PACEMAKER	☐ YES ☐ NO	SEIZURES	☐ YES ☐ NO
KIDNEY DISEASE	☐ YES ☐ NO	PNEUMONIA	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO
GOITER	☐ YES ☐ NO	POLIO	☐ YES ☐ NO	CANCER	☐ YES ☐ NO
GOUT	☐ YES ☐ NO	HERNIATED DISC	☐ YES ☐ NO	ANEMIA	☐ YES ☐ NO
PARKINSON'S	☐ YES ☐ NO	SPINE ISSUES	☐ YES ☐ NO	ULCERS	☐ YES ☐ NO
ALS	☐ YES ☐ NO	ARTHRITIS	☐ YES ☐ NO	THYROID ISSUES	☐ YES ☐ NO
HEPATITIS C	☐ YES ☐ NO	STROKE	☐ YES ☐ NO	IBS	☐ YES ☐ NO
LIVER DISEASE	☐ YES ☐ NO	OSTEOPOROSIS	☐ YES ☐ NO	EMPHYSEMA	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	CATARACTS	☐ YES ☐ NO	ASTHMA	☐ YES ☐ NO
VALLEY FEVER	☐ YES ☐ NO	MULTIPLE SCLEROSIS	☐ YES ☐ NO	HEART DISEASE	☐ YES ☐ NO
ALZHEIMER'S DISEASE	☐ YES ☐ NO	CROHN'S DISEASE	☐ YES ☐ NO	EPILEPSY	☐ YES ☐ NO
WEIGHT LOSS	☐ YES ☐ NO	ABDOMINAL PAIN	☐ YES ☐ NO	SCHIZOPHRENIA	☐ YES ☐ NO
TROUBLE SLEEPING	☐ YES ☐ NO	TUMORS / GROWTHS	☐ YES ☐ NO	ANXIETY / DEPRESSION	☐ YES ☐ NO

PLEASE LIST ALL SURGERIES AND HOSPITALIZATIONS YOU HAVE EXPERIENCED WITH THE DATE OF OCCURRENCE:

1 _____

2 _____

3 _____

PLEASE LIST WHEN, WHERE, AND WHY YOU HAD ANY OF THE FOLLOWING:

X-RAYS: _____

ULTRASOUNDS: _____

MRI / CAT SCANS: _____

OTHER TESTS: _____

PLEASE INDICATE YOUR USE OF THE FOLLOWING:

STEROIDS ☐ CURRENT ☐ PAST ☐ NA

DRUG ADDICTION ☐ CURRENT ☐ PAST ☐ NA

SMOKING ☐ CURRENT ☐ PAST ☐ NA

ALCOHOL ☐ CURRENT ☐ PAST ☐ NA

RECREATIONAL DRUGS ☐ CURRENT ☐ PAST ☐ NA

HOW MANY PACKS PER DAY? _____ NUMBER OF YEARS? _____

HOW MANY DRINKS PER WEEK? _____

PLEASE LIST ALL MEDICINES AND SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING. PLEASE INCLUDE DOSAGE AMOUNTS IF KNOWN.

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

IN YOUR OWN WORDS, PLEASE DESCRIBE HOW YOUR CONDITION LIMITS YOU OR DECREASES YOUR QUALITY OF LIFE:

I certify that the information, both written and verbal, that I have provided to Sun Valley MMJ Certification Clinic is true and accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**

ARIZONA DEPARTMENT OF HEALTH SERVICES
MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA PATIENT ATTESTATION

I, _____, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

Arizona Department of Health Use Agreement

You are about to access a system within the Arizona Department of Health Services (ADHS) computer network. Use of this system constitutes users' consent to permit ADHS monitoring of users' activities. Evidence of unauthorized activities obtained during monitoring can and will be used by ADHS for criminal prosecution as permitted by law.

Please note that local jurisdictions may impose additional fees and/or requirements for home cultivation. Please check with your local jurisdiction for any additional information.

Please note that if you choose to designate a caregiver for this purpose, you as a patient cannot also cultivate. Once you have designated a caregiver, the caregiver application process must also be completed. The designated caregiver application can be completed at:http://www.azdhs.gov/medicalmarijuana/caregivers/index.htm. Please take special note of caregiver-specific application instructions.

For your own protection and confidentiality, the system will not display saved information once a page is exited.

By submitting this application I am acknowledging that I am aware that:
The sale, manufacture, distribution, use, possession, etc., of marijuana is illegal under federal law. A registry identification card or registration certificate issued by the Arizona Department of Health Services pursuant to Arizona Revised Statutes Title 36, Chapter 28.1 and Arizona Administrative Code Title 9, Chapter 17 does not protect me from legal action by federal authorities, including possible criminal prosecution for violations of federal law.

I understand 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 (“Act”), Arizona Revised Statutes Title 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.

_____ _____

Patient Signature **Date**

CONTRADICTIONS AND SIDE EFFECTS ACKNOWLEDGMENT

Cannabis (marijuana) may affect or impair coordination and cognition, as well as the ability to drive, operate heavy machinery and/or engage in potentially hazardous activities.

Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in marijuana smoke, because although smoking cannabis (marijuana) has not been linked to lung cancer, smoking it can cause respiratory harm such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. Cannabis smoke contains chemicals known as tars that may be harmful to health.

The side effects, while rare, may occur while taking medical cannabis. These side effects can include, but are not limited to the following:

- Anxiety
- Inability to concentrate
- Difficulty in completing complex tasks
- Sedation
- Alterations in the perception of time and space
- Impairment of motor skills, reaction time and physical coordination
- Low blood pressure
- Dizziness
- Increased appetite
- Increased talkativeness
- Impairment of short-term memory
- Confusion
- Euphoria
- Cough
- Tachycardia (fast heart beat) and heart palpitations
- Paranoia
- Suppression of the body's immune system
- Psychotic symptoms (e.g., delusions, hallucinations)

The potency and effects of cannabis varies. For some patients, chronic marijuana use can lead to laryngitis, bronchitis and general apathy. Some patients can become psychologically dependent on marijuana and could experience withdrawal symptoms when they stop. Symptoms of withdrawal, while generally mild, can include:

- Feelings of depression, sadness or irritability
- Sleep disturbances
- Trouble concentrating
- Loss of appetite

Cannabis is not a food crop and therefore is not regulated by the U.S. Food and Drug Administration and may contain unknown quantities of impurities, active ingredients and/or contaminants. While under the influence of marijuana, the use of alcohol is not recommended. The possibility exists that cannabis may exacerbate schizophrenia in persons predisposed to that disorder.

I HAVE READ AND UNDERSTAND THE STATEMENTS ABOVE AND UNDERSTAND THE POTENTIAL SIDE EFFECTS OF CONSUMING MARIJUANA.

Patient Name (Printed)	Patient Signature	Date

LIABILITY WAIVER AND RELEASE

In consideration of my medical evaluation to be performed by or on behalf of Sun Valley MMJ Certification Clinics, LLC, I, _____, my heirs, assigns and anyone acting on my behalf, agree to hold Sun Valley MMJ Certification Clinics, LLC, staff, physicians, and their principals, agents, officers, directors and employees free and harmless from any and all claims, damages and causes of action relating to or arising out of: (1) my use or possession of cannabis (marijuana), or (2) the denial of my application for a medicinal marijuana card for any reason.

I understand and acknowledge that:

1. Sun Valley MMJ Certification Clinics, LLC is not a Dispensary and cannot provide me with medicinal marijuana or any other medication.
2. A physician's recommendation that I may benefit from the use of medicinal marijuana does not guarantee that the use of medicinal marijuana will be effective at alleviating or helping my pain or any other qualifying condition.
3. If I do not wish to upload my application to the Arizona Department of Health Services today with the help of Sun Valley MMJ Certification Clinics, LLC, then I will have 90 days from the date of being issued a signed physician certification form to apply to the state for a legal medical marijuana card. If I miss the 90 day window for application to the AZDHS, I will be required to be re-evaluated by a physician and pay whatever fees are required for re-evaluation.
4. I am responsible to know the Arizona State laws regarding legal acquisition and use of medical marijuana -- information available to me on the AZDHS.gov website.
5. Neither Sun Valley MMJ Certification Clinics, LLC nor anyone acting on Sun Valley MMJ Certification Clinics, LLC's behalf has made any representation to me about the application or enforcement of state or federal law in connection with the possession or use of medicinal marijuana.
6. Neither Sun Valley MMJ Certification Clinics, LLC's physicians, associates nor staff address specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician; and
7. Neither Sun Valley MMJ Certification Clinics, LLC's physicians, associates nor staff advises or condones that I discontinue treatment or medication that I currently take.

In addition, I represent that Sun Valley MMJ Certification Clinics, LLC's Physicians have: (a) explained to me the nature and purpose of medical cannabis (marijuana) treatment, including its benefits and possible side effects; (b) asked me if I have any questions regarding his/her recommendation; and (c) answered those questions, if any, to the best of his/her ability.

ACKNOWLEDGED AND AGREED:

Patient Name (Printed)	Patient Signature	Date

SUN VALLEY MMJ
CERTIFICATION CLINIC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Sun Valley MMJ Certification Clinic's Notice of Privacy Practices.

Name of Patient (please print)	**Date of Birth**
Patient Signature	**Date**

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At *Sun Valley MMJ Certification Clinic*, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective October 1, 2013 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit *Sun Valley MMJ Certification Clinic*, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of *Sun Valley MMJ Certification Clinic*, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Sun Valley MMJ Certification Clinic is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Andrea Klein at 623-847-6652.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

*Organ procurement organization*s: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.