PURECANN *Patient Questionnaire* Date _____

Type: New / Renewal Circle Renewal if recommendation has expired within the last 30 days

Name _____ Date of Birth _____ Age _____ Gender ☐ Male ☐ Female
Height _____ Weight _____ Email Address _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____

Current employment?_____ How did you hear about PureCann?_____

MEDICAL HISTORY CURRENT MEDICAL COMPLAINT *List the medical problems for which you use or would like to use medical marijuana, include year of onset of symptoms*

_____

PRIMARY CARE PROVIDER *Please give the name & address of your healthcare provider (includes chiropractor/ psychologist / acupuncture, etc.) Please also list the date you were last seen*

_____

MEDICATIONS *List all of your medications (include prescription and over-the counter)*

_____

List any medications that you are allergic to _____

OTHER TREATMENTS *Check any other treatments you use for your condition* ☐surgery ☐physical therapy ☐chiropractic ☐massage ☐herbal therapy ☐counseling ☐exercise ☐ other _____

SURGICAL HISTORY *Please list the surgeries that you have had*

_____

How do your symptoms interfere with your life? Check all that apply ☐Poor sleep ☐Unable/limits my ability to work ☐Unable/limits exercise ☐Interferes with personal relationships ☐Increases stress/depressed mood ☐ Other:

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? ☐Asthma/Lung Disease, ☐Cancer, ☐HIV/AIDS, ☐Diabetes, ☐Hepatitis, ☐Epilepsy/Seizures, ☐Stroke, ☐Liver Disease, ☐Kidney Disease, ☐High Blood Pressure, ☐Heart Disease, ☐Sleep Disorders (Sleep apnea, insomnia), ☐Substance Abuse, ☐Intestinal Disorders (IBS, Ulcers), ☐Multiple Sclerosis, ☐ADD/ADHD, ☐Psychiatric Disorders (depression, anxiety, etc.)

DRUG & ALCOHOL HISTORY DO YOU CURRENTLY USE *Tobacco?* ☐Yes ☐No If yes, number of cigarettes per day: _____ *Alcohol?* ☐Yes ☐No If yes, number of drinks per week: _____

MARIJUANA HISTORY *Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition?* ☐Yes ☐No *If yes, which medication(s) have you reduced or eliminated and why?*

_____ _____

How often do you use marijuana? ☐every day or almost every day ☐about 1 -2 times per week ☐more than once a month

What is your preferred method of using marijuana? ☐smoke ☐vaporizer ☐ingested ☐topical *How effective is marijuana for your medical problem?* ☐very effective ☐effective ☐only somewhat effective

How does marijuana improve your symptoms? _____

Have you been evaluated by another physician for medical marijuana? ☐Yes ☐No *If yes, list the name of the practice, doctor, and date seen* _____

FEMALE PATIENTS ONLY *Are you pregnant?* ☐Yes ☐No *Are you currently breastfeeding?* ☐Yes ☐No

ADDITIONAL INFORMATION *Do you have an open court case regarding marijuana?* ☐Yes ☐No *Are you currently on probation?* ☐Yes ☐No *Please provide any additional information that may be relevant to the physician evaluation*

_____

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

_____**Patient Signature Print Name** _____

Date

PureCann Patient Acknowledgement

I understand that: *(Please initial each statement)*

_____ The attending physician, staff and/or representatives of PureCann are neither providing, dispensing nor encouraging me to obtain medical marijuana.

_____ The attending physician, staff and or representatives of PureCann will NOT be providing or discussing information regarding dispensaries, co-ops, collectives, delivery services or any other way to obtain marijuana.

_____ The physician, staff and representatives of PureCann are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

_____ My initial fee allows me a free visit. Subsequent visits will be charged on a per visit basis.

_____ Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the physician. It is my responsibility to arrange my appointment with the physician for a reassessment of my medical condition.

_____ I acknowledge and represent that I am a resident of California.

_____ I acknowledge and represent that I am over 18 years of age.

_____ I acknowledge and represent that I am not an agent of law enforcement, state or federal government, here for the purpose of investigation or entrapment.

_____ I acknowledge and represent that I am not recording any portion of my visit with PureCann nor do I possess any recording equipment. I understand PureCann does not approve such action.

_____ I acknowledge that it is up to me to become a patient of PureCann. If I decide not to be a patient after my evaluation, I understand there will be no fee. In the event that I do pay and elect to be a patient of PureCann, I understand there will be no refunds.

_____ I acknowledge and represent that all of the information I have provided to PureCann is true and correct and that I have not misrepresented any information to PureCann.

_____**Patient Name (Please print)** _____**Patient Signature Date**

PureCann Informed Consent

I am being evaluated for a physician's recommendation for medical marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I have been informed of and understand the following: *(Please initial each item)*

1. _____ I must be a California resident to obtain an approval or recommendation for the use of (medical marijuana) under California's Compassionate Use Act of 1996 (Health & Safety Code Section 11362.5).

2. _____ I understand the cultivation, distribution, possession, and use of marijuana is federally illegal. The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as California, which have modified their state laws to treat marijuana as a medicine.

3. _____ I understand that marijuana has not been approved by the Food and Drug Administration for use as a treatment modality. I understand that marijuana for medical use is not subject to any standards, quality control, or other oversight. I understand that marijuana may contain unknown quantities of active ingredients, can vary in potency, and may contain impurities, contaminants, and unknown substances.

4. _____ I understand that the use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, I will not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

5. _____ I understand that potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low or high blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment.

6. _____ I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

7. _____I agree to contact PureCann if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact PureCann if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

8. _____I understand that smoking marijuana may cause respiratory problems and harm, including chronic bronchitis, emphysema and laryngitis. Marijuana smoke is known to contain known carcinogens (chemicals that can cause cancer) and other harmful chemicals. Smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician.

9. _____I understand that the risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

10. _____I understand that individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I will contact the physician at PureCann.

11. _____I understand that signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

12. _____I understand that symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact the physician at PureCann immediately or go to the nearest emergency room.

13. _____If the physician or staff at PureCann subsequently learn that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with the physician at PureCann and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

14. _____I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. **I acknowledge that the physician at PureCann has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The physician also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the PureCann physician informed me of alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.**

_____Patient Name (Please print) _____Patient Signature Date

PureCann Authorization for Release of Information Please initial next to each entry to which you agree:

_____ I hereby authorize PureCann to disclose my records solely for the purpose of verification. I understand that I am only verifiable as a current medical marijuana patient for the period of time for which the recommendation for medical marijuana has been issued by my PureCann physician. _____ I hereby authorize PureCann to verify my status as a PureCann patient via the PureCann online or phone-in Patient Verification System.

_____ I hereby authorize the use and disclosure of my PureCann patient records, except for personal identifying information, for use in data analysis of cannabis-treated patients.

_____ I hereby authorize PureCann to disclose and verify my medical records to law enforcement should I be arrested or detained related to my possession or use of medical marijuana. I understand that PureCann will only provide verification of my patient status for the purpose of providing proof to justify my possession of medical marijuana. I understand that I am only verifiable as a current medical marijuana patient for the period of time for which the recommendation for medical marijuana has been issued by my PureCann physician.

_____In the event that I decide to apply for the voluntary state Medical Marijuana ID Card program, I understand that the physician at PureCann will be contacted by the state and will be required to sign a document stating that I was approved for the use

of medical cannabis in order for my application to be complete. I hereby authorize PureCann and its physicians to release medical information to the California Department of Public Health and/or _____ (insert name of the County in which you reside) as may be necessary for the issuance of the state ID card. I understand that this information may not be further disclosed or used by the recipient for any other purpose without my authorization, except as permitted by state law governing access to the statewide registry of authorized ID card holders. This authorization expires one year from the date set forth below. **I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and PureCann will not condition my treatment on my providing authorization for the requested use or disclosure. Notwithstanding anything to the contrary, this authorization will expire no later than twelve (12) months from the date of my signature below. I understand that I am entitled to receive a copy of this authorization.**

_____**Patient Name (Please print)** _____**Patient Signature Date**

Acknowledgement: Review of Notice of Privacy Practices

I hereby acknowledge that I have been made aware of the Notice of Privacy Practices for PureCann. I understand that I may obtain additional copies upon request, as described in the Notice. Each office has our privacy policy posted in the waiting room. You can also find our privacy policy online at www. PureCann.com. This Acknowledgement will be filed with my records.

_____**Patient Name (Please print)** _____**Patient Signature Date**

Signature Date PAGE 1 OF 1

Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to binding arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement binds patient and anyone else who may have a claim arising out of or related to all treatment or services provided by physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court proceeding by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration. Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within 30 days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issue of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties further agree that the arbitration conducted pursuant to this agreement shall be final and binding. The prevailing party shall be entitled to reasonable fees incurred due to the arbitration, including arbitration fees, counsel fees, witness fees, or other expenses incurred by the prevailing party. The parties agree that the statutory provisions of California applicable to health care providers shall apply to disputes within this agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration. Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient. Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial below .

Patient's Initials: _____ If any provision of this agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. Patient understands that he/she has the right to receive a copy of this agreement. By my signature below, patient acknowledges that he/she has received a copy. **NOTICE: BY SIGNING THIS CONTRACT PATIENT IS AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND IS GIVING UP PATIENT'S RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.**

_____**Patient Name (Please print)** _____**Patient Signature Date**