Highland Springs Wellness Center

1061 E. Main Street, Suite 204
Grass Valley, CA 95945
Phone: 530.274.2274 Fax: 530.274.2559

Medicare / Medicaid / MediCal

(ALL patients must sign)

Please be advised that we do not bill Medicare, Medicaid, or MediCal for our services. By signing below, you agree NOT to request reimbursement from Medicare, Medicaid, or MediCal for your visits at Highland Springs Wellness.

_____	_____	_____
Patient Name Printed	Patient Signature	Date

_____	_____	_____
Physician Name Printed	Physician Signature	Date

Highland Springs Wellness Center

CANNABIS PATIENT HISTORY

Date: _____ **Do you have private insurance? ___Yes ___No**

NAME: _____ Birthdate: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

_____ _____ _____

CELL HOME WORK

Email:_____ Fax:_____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Did you bring medical records today? __Y __N If yes, what are they?_____

CURRENT MEDICAL CONDITIONS:_____

_____

Are you currently enrolled in school? ___Yes ___No Please specify: ___HS ___College ___Other

Are you currently on parole or probation? ___Yes ___No

Are you currently pregnant? ___Yes ___No Are you planning a pregnancy? ___Yes ___No

Are you married/with a partner___? Single___? Divorced___?

Do you have any children? ___Yes ___No What are their ages?_____

Have you been evaluated for use of medicinal cannabis by us or any other physician in the past? ___Yes ___No

If yes, please give name of doctor, dates seen, and conditions seen for:_____

_____

Have you ever been denied a medicinal cannabis recommendation by us or any other physician? ___Yes ___No

If yes, please explain:_____

Are you currently attending or have you ever attended a drug/substance abuse or rehab program? ___Yes ___No

Name of program: _____ Dates entered:_____

Any suicide attempts or thoughts? ___Yes ___No How often? _____

OVER ⇒

Do you currently have a primary care physician? ___Yes ___No

If yes, what is physician's name:_____

Physician's phone: _____ Fax: _____

Physician's address:_____

If no, what doctor or medical facility did you visit for your current conditions? _____

_____

Who are your other current health practitioners (specialist, surgeon, chiropractor, acupuncturist, naturopath, massage therapist, psychiatrist, counselor)? _____

_____

_____

Do you currently use tobacco? ___Yes ___No How much per day? _____ How many years?_____

Do you currently use alcohol? ___Yes ___No How much, how often? _____ How many years?_____

Do you currently use marijuana? ___Yes ___No How often? _____

Are you taking any medications? ___Yes ___No List medications & dosages: _____

_____

_____

Are you <u>allergic</u> to any medications? ___Yes ___No Please list: _____

_____

Have you ever been hospitalized? ___Yes ___No Give dates & details:_____

_____

_____

Have you ever had surgery? ___Yes ___No Give dates & details:_____

_____

_____

List all diagnostic tests done (e.g., MRI, CT, X-ray): _____

Do you <u>consistently</u> have any of the following? ___Check here if NONE

___ Fever	**___ Vomiting**	**___ Skin rashes**	**___ Stomach pain**	**___ Menstrual cramps**
___ Nausea	**___ Insomnia**	**___ Depression**	**___ Alcohol abuse**	**___ Lupus, scleroderma**
___ Anxiety	**___ Coughing**	**___ Palpitations**	**___ Irritable bowel**	**___ Rheumatoid arthritis**
___ Seizures	**___ Joint pain**	**___ Chronic pain**	**___ Muscle spasms**	**___ Difficulty swallowing**
___ Arthritis	**___ Heartburn**	**___ Constipation**	**___ Crohn's disease**	**___ Sedative/opiate habit**
___ Diarrhea	**___ Chest pain**	**___ Brain trauma**	**___ Loss of appetite**	**___ Restless leg syndrome**
___ Hepatitis	**___ Headaches**	**___ Eye problems**	**___ Multiple Sclerosis**	**___ Peripheral neuropathy**

___ Other: _____

Do you use <u>less</u> of other medications/drugs (including alcohol & tobacco) because of cannabis? ___Yes ___No

Which ones?_____

Do you use cannabis <u>instead</u> of other medications/drugs (including alcohol & tobacco)? ___Yes ___No

Which ones?_____

Highland Springs Wellness Center

MEDICINAL CANNABIS CONSENT

_____ Initial here

Cannabis use has potential risks. I understand that I should not use cannabis with alcohol or other mind-altering substances, and that I should use the minimum dose necessary to relieve my symptoms. I also understand that long-term smoking of cannabis can be harmful to my lungs, and that cannabis can adversely affect my ability to safely drive a motor vehicle, operate equipment, or engage in other potentially hazardous activities. I agree not to drive under the influence of cannabis.

_____ Initial here

I understand that if I am currently involved in any court proceeding, on parole or probation, or using illegal drugs, it is my responsibility to inform my healthcare practitioner before receiving a medical cannabis approval. If these facts are withheld and then discovered at a later date, I understand that my approval will be voided.

_____ Initial here

I understand that if for any reason I am not approved for medicinal cannabis, you will refund my office visit payment, minus a $50 assessment fee.

_____ Initial here

I agree not to request reimbursement from Medicare, Medicaid, or MediCal.

Please also ***initial*** ONE of the following options

OPTION **A:** (THIS CAN PREVENT YOUR ARREST IF YOU ARE STOPPED.)

_____ I permit Dr. Devlin's staff to verify my approval if cannabis clubs or law enforcement officers call for validation.

OPTION **B:** (IF YOU GET INTO TROUBLE, WE CANNOT SPEAK TO ANYONE.)

_____ I do NOT permit Dr. Devlin's staff to verify my cannabis approval to anyone, for any reason whatsoever.

PRIVACY PRACTICES

The Department of Health and Human Services has established a "Privacy Rule" to ensure that your personal information is protected. Health care providers must have your consent before using or disclosing your health information to carry out treatment, obtain payment, or conduct health operations. We respect the privacy of your personal medical information and will do everything possible to secure and protect that privacy. We will also provide you with full access to your medical records.

We are required by law to offer you a copy of our Notice of Privacy Practices for Health Information, which is available for reading in our waiting room. Please let us know if you want your own copy. By signing below, you acknowledge that the NPP was offered to you as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Signature Date

OVER ⇒

Highland Springs Wellness Center

RELEASE OF LIABILITY

I understand that I must be a California resident to obtain an approval or recommendation for the use of medicinal cannabis under California's Compassionate Use Act of 1996 (Health and Safety Code # 1136.5).

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found that—or am interested in learning if—medicinal cannabis provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration, and may therefore contain unknown quantities of active ingredients, impurities, and/or contaminants. In requesting an approval or recommendation for the use of cannabis as medication, I assume full responsibility for any and all risks involved in this action.

I understand that cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should I experience respiratory problems or other ill-effects from cannabis, I should discontinue its use and report the problems to my physician.

I understand that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive a vehicle, operate machinery, or engage in other potentially hazardous activities. I assume full responsibility for any harm that comes to me and/or other individuals as a result of my using cannabis.

California's Compassionate Use Act of 1996 (Health and Safety Code # 1136.5) provides for the possession and cultivation of cannabis (medical marijuana) for the personal medical purposes of the patient with a physician's approval or recommendation. I completely and clearly understand that the physician, staff, and representatives of this practice are neither providing cannabis (medical marijuana), nor encouraging any illegal activity in the obtaining of cannabis.

I understand that on rare occasions patients have been arrested for possessing cannabis on federal property within the state of California. This could possibly occur at VA hospitals, Air Force bases, National Parks, BLM lands, and other federally owned property.

I understand that there are no conclusive studies regarding the use of cannabis during pregnancy or lactation, and that using cannabis under these conditions may cause harm to the fetus or child.

I hereby request a consultation with the physician or physician's assistant for purposes of determining the appropriateness of medicinal cannabis treatment. I understand that this practice makes no claims about the medical efficacy of cannabis. I also understand that the physician, staff, and representatives are addressing specific aspects of my medical care, and that unless otherwise stated are in no way establishing themselves as my primary care provider. Should I receive an approval for the medical use of cannabis, I understand that it will expire at a date specified by the physician or physician's assistant. I understand that it is my responsibility to see the physician again to assess the possibility of renewing my cannabis approval. Furthermore, I, my heirs, assigns, and anyone acting on my behalf hold the physician and his/her principals, agents, and employees free of and harmless from any liability resulting from my use of cannabis.

AFFIDAVIT: I swear that I am not working for—nor here to entrap or gather evidence for—any local, state, or federal law enforcement agency (e.g., the DEA, FBI, CIA, FDA, or ATF). If I am approved to use medicinal cannabis, I swear I will not cultivate or distribute medical marijuana outside the confines of the law.

_____

Patient Signature Date

OVER ⟹