#1

WCMIORTHO
Orthopedics at its best

W: WCMIOrtho.com
P: 352-556-4823
F: 352-556-4824

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

DOB: _____ SSN: _____ Sex: M / F Occupation: _____

Street Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Care Physician: _____ Phone: _____ Marital Status: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Today's Date _____ Date of Injury: _____ Are you: Right-handed / Left-handed

Preferred Pharmacy (with cross streets) _____
How did you hear about WCMI? _____

ONLY IF PATIENT IS A MINOR- RESPONSIBLE PARTY INFORMATION- Please fill in ALL blanks.

First Name: _____ MI: _____ Last Name: _____

Sex: M F Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____Zip Code: _____

Minor Pre-Authorization for Medical Care

I request and authorize West Coast Musculoskeletal Institute and its personnel to deliver medical care to my child listed above.

Guardians Name (Print): _____ Guardians Signature: _____

Relationship to patient (Print) _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Ht: _____ Wt: _____lbs Age: _____

Why are you here today? _____

SYMPTOMS:

Location: _____
(Where is the pain? Does it travel to other areas?)

Quality: _____
(Is the pain dull, throbbing, sharp? If bump, is it warm, tender, red?)

Severity: _____
(How severe on a scale of 1-10 with 10 being most severe?)

Duration: _____
(How long have you had this pain/problem? When did it start?)

Time: _____
(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?)

Context: _____
(What were you doing at the onset of the pain/problem?)

Associated signs/symptoms: _____
(Do you have numbness? Abnormal sounds: cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?)

Modifying factors: _____
(What makes the problem worse or better? Example: Activities)

Name: _____ DOB: _____

HISTORY OF PRESENT ILLNESS:

Have you ever experienced any injury or symptoms regarding this body part? Yes No

If so, please provide details:

_____

_____

Please list any hobbies/sports you enjoy:

_____

Which of the above activities are your unable to perform due to your pain?

_____

Have you seen any other physicians regarding THIS condition prior to coming to our office: Yes No

Doctor	**When**	**Tests**	**Results**	**Treatment**

_____

_____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please circle all pertinent information:*

AIDS or HIV	Cancer	Hepatitis	Mumps	Thyroid Disease
Anemia	Chicken Pox	High Blood Pressure	Pneumonia	Tuberculosis
Arthritis	Diabetes	Infectious Mono	Polio	Ulcer
Asthma	Diphtheria	Kidney Disease	Rheumatic Fever	Venereal Disease
Back Trouble	Epilepsy/Seizures	Low Blood Pressure	Scarlet Fever	Whooping cough
Bladder Infections	Glaucoma	Measles	Sleep Apnea	Other (please list)
Bleeding Tendency	Heart Disease	Migraine Headache	Smallpox	
Blood Transfusions	Hemorrhoids	Mitral Valve Prolapse	Stroke	_____
Bronchitis	Dementia	COPD	Fibromyalgia	_____
				_____

Please list **all medications** you are taking (Include non-prescription and herbal supplements):

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Are you allergic to any medications?

Medication	Reaction			
_____		Tape Allergy:	Yes	No
		Latex Allergy:	Yes	No
_____				

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

_____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

PATIENT SOCIAL HISTORY:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
Single	Never	Never	With Family
Married	Rarely	Previously, but quit	With Friends
Divorced	Moderate	Currently	Alone
Widow	Daily	___ packs per day	Other_____

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
	_____	_____	_____

REVIEW OF SYSTEMS:

Please indicate any personal history below:

Musculoskeletal

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles/joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold Extremities	No	Yes
Difficulty in walking	No	Yes

Constitutional Symptoms

Bad general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic Sinus Problems	No	Yes
Nose Bleeds	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular

Heart Trouble	No	Yes
Chest pain or angina	No	Yes
Palpitations	No	Yes
Shortness of breath while walking	No	Yes
Swelling of feet, ankles or hands	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
F-number of pregnancies	_____	
F-number of deliveries	_____	

Integumentary (skin, breast)

Rash or itching	No	Yes
Changes in skin color	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes

Neurological

Light headed or dizziness	No	Yes
Numbness/tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

Hematologic/ Lymphatic

Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Enlarged glands	No	Yes
Slow to heal after cuts	No	

Endocrine

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry Skin	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness/ Anxiety	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding/ blood in stool	No	Yes
Abdominal pain	No	Yes

Respiratory

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/ contact lens	No	Yes
Blurred or double vision	No	Yes

Allergic/ Immunologic

List Food/ environmental allergies:

_____
_____
_____
_____
_____

FEMALE PATIENTS:

Are you currently pregnant? Yes / No
Are you planning to get pregnant? Yes / No
Are you currently breast feeding? Yes / No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medial status. I also authorize the health care staff to perform the necessary services I may need.

_____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

Pre-Qualification Questionnaire

Are you a Florida resident? Yes / No
Do you have a valid Florida ID? Yes / No
Have you been arrested or charged with a crime in the past two years? Yes / No
(If yes, please describe)

_____

_____

Are you currently on parole or probation? Yes / No **(If yes, please see clinic manager)**

Have you been evaluated for medical marijuana use by another physician in the past? Yes / No
(If yes, please give name of practice, doctor, date seen, and condition for evaluation)

_____

_____

Have you been denied a recommendation for medical marijuana use by another physician in the past? Yes / No
(If yes, please explain)

_____

_____

Are you currently attending or have you attended any substance abuse or rehabilitation program? Yes / No
(If yes, please provide details)

_____

_____

Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No
(If yes, please provide details)

_____

_____

Did you bring any medical records with you today? Yes / No (If yes, what did you bring)

_____

_____

Do you currently use marijuana? Yes / No (If yes, how often)

_____

_____

Do you currently drink alcohol? Yes / No (If yes, how often)

_____

_____

Do you currently use cocaine, methamphetamine, opiates, heroin, or other street drugs? Yes / No
(If yes, please explain)

_____

_____

_____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, West Coast Musculoskeletal, PL originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment
* A means of communication among the many health professionals who contribute to my care
* A source of information for applying my diagnosis to my bill
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review and the notice prior to signing this consent. I understand that the Practice reserves the right to change its notice and practices, and prior to implementation, will mail a copy of my revised notice to the address I've provided I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions of how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Notification of Family Members: I authorize discussion of my medical condition and payment options with:

_____

Name and Phone Number Name and Phone Number

_____

Name and Phone Number Name and Phone Number

I request the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that WCMI may leave voicemail messages for appointment reminders.

I certify that I am the patient of the patient's legal representative, and that the information provided is the correct and complete. I understand, acknowledge, and agree to the terms set forth above.

I also herby authorize West Coast Musculoskeletal Institute to download my medication and Rx history and Rx benefits into my account from an Rx clearinghouse.

_____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

WCMIORTHO
Orthopedics at its best

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective Date: March 24, 2017

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. ✧ We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. ✧ We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12months.

Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. • *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*

Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: ✧ Preventing disease. ✧ Helping with product recalls. ✧ Reporting adverse reactions to medications. ✧ Reporting suspected abuse, neglect, or domestic violence. ✧ Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ✧ For workers' compensation claims. ✧ For law enforcement purposes or with a law enforcement official. ✧ With health oversight agencies for activities authorized by law. ✧ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Name: _____ DOB: _____

OUR RESPONSIBILITIES

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a comment or complaint about our privacy practices by:
1) Mail to West Coast Musculoskeletal Institute, 14555 Cortez Boulevard, Brooksville, FL. 34613;
2) Email to info@wcmiortho.com;
3) Phone (352)556-4823;
4) Written communication to the facility following the process outlined in our Company's Patient Rights documentation; and/or
5) Written communication to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You will not be penalized for filing a complaint.

Name: _____ DOB: _____

RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize West Coast Musculoskeletal Institute to discuss of my medical condition.

I understand that I must be a Florida State resident to obtain an approval or recommendation for the use of Low-THC cannabis or medical cannabis under the Compassionate Medical Cannabis Act of 2014.
I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether medical marijuana 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 therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

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

The Florida Office of Compassionate Use (HB 307 effective March 27, 2016) provides for the possession for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of medical marijuana.
I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

_____ _____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio. This is a direct violation of HIPPA regulations and patient/doctor confidentiality. I am aware that my recommendation can be revoked at anytime and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize West Coast Musculoskeletal Institute, or its representative to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient.

Patient Name (Print): _____Telephone Number: _____

Patient Signature: _____Alt. Phone Number: _____

Current Address: _____ City: _____ State: _____ Zip: _____

_____ The attending physician will fully explain to me the nature and purpose of medical marijuana treatment, including its benefits and possible side effects.

_____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

Acknowledgements, Agreements, Disclosures, and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree to each item. By initialing, you understand and agree to the information disclosed. If you have questions or do not understand the information below, consult with the attending physician before initializing or signing this agreement. Please do not sign this agreement and do not use marijuana if you do not understand the information you have received.

I, _____, (Patient's Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: cancer and a physical condition that chronically produces seizures or severe and persistent muscle spasms. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)
- Other conditions for which marijuana provides relief
- If not alleviated, may cause harm to the patient's safety or physical or mental health

Patient agrees by initialing the following *(Please Initial)***:**

_____I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery, drive, or engage in potentially hazardous activities.

_____I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia psychotic symptoms and overeating.

_____I understand that some patients become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

_____I understand that chronic use of medical marijuana can lead to laryngitis, bronchitis and general apathy.

_____I understand that although marijuana does not produce a specific psychosis, the possibilities exists that is may exacerbate schizophrenia in persons predisposed to that disorder.

_____I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition.

_____I understand there are few known interactions between marijuana and medications other than herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements, or other medications.

_____I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of Marijuana as a drug. I understand the significance of this fact.

_____I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

_____ _____

Signature of Patient/Parent of Minor/Legal Represented Date

Name: _____ DOB: _____

_____I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

_____I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

_____I understand Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, disturbances to heart rhythms, numbness in the limbs, anxiety attacks and incapacitation.

_____If I start taking medical marijuana, I agree to tell my attending physician if I: Start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking.

_____I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

_____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.

_____I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

_____Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

_____I am not permitted to use medical marijuana products within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

_____I agree to follow up with the attending physician at West Coast Musculoskeletal Institute with supporting medical records pertaining to my medical conditions.

_____I understand the attending physician, staff, and/or representatives, of West Coast Musculoskeletal Institute, are neither providing, dispensing, nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and/or representatives of West Coast Musculoskeletal Institute will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

_____I understand the attending physician, staff, and/or representatives, of West Coast Musculoskeletal Institute, are neither providing, dispensing, nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and/or representatives of West Coast Musculoskeletal Institute will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

_____The physician, staff, and representatives of West Coast Musculoskeletal Institute are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals because of my medical marijuana use.

_____ _____

Signature of Patient/Parent of Minor/Legal Represented Date