

Arkansas Progressive Medicine

Patient Intake Form

Name: _____

Date of Birth: _____ Race: _____

Home Phone: _____ Cell: _____

Email: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Sex: M or F (*circle one*) Eye Color: _____ Height: _____

AR Driver's License #: _____ or State ID Card #: _____

DL Expiration Date: _____ Last 4 Digits of SSN: _____

How did you hear about us?: _____

Have you had any surgeries or broken bones? If yes, please explain: _____

Please list medications, both prescription and over-the-counter: _____

List all allergies to medications: _____

Primary Care Doctor

Name: _____ Phone: _____ Fax: _____

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

If there is no visit in the past 10 years, please state why: _____

Patient Statement Regarding Primary Diagnosis and Medical Records

Have you seen a doctor or been to a clinic for your medical symptoms / problems?

Please circle **Yes** or **No** here

1. If you answered YES, then please provide us with a copy of your medical records, x-rays, and prescriptions from your treating physician / clinic (*the doctor you listed on Page 1*)
2. If you answered YES but CANNOT provide the medical record copies, then please provide the following information:

I cannot provide the records because: _____

Your personal statement regarding the above facts:

I, (print your name) _____, confirm that the information provided by me regarding my diagnosis and medical records is true and correct.

X _____
Patient's Signature Date

Disclosures and Conditions

- Based on my beliefs and awareness of researched scientific evidence of the benefits of medical cannabis, I request that the doctor evaluate me for a recommendation to use medical cannabis. This would enable me to legally obtain medical marijuana to use for treatment of my medical conditions.
- If medical cannabis adversely affects my health, I will stop using medical cannabis. I assume all risk for the use of medical cannabis.
- I agree to obtain medical follow-up at my personal medical doctor's office, or obtain a personal doctor I have none now and to return this office for follow-up as recommended by the physician. I understand this is an obligation on my part for the continuity of care.
- I agree NOT TO DRIVE or operate heavy equipment while using medical cannabis.
- I DO NOT plan or intend to use my physician's recommendations for the purpose of illegally obtaining medical cannabis.
- I understand that I MUST be a Arkansas resident to obtain an approval or recommendation for the use of medical cannabis under Arkansas law. I affirm that I have a serious medical condition that adversely affects my quality of life.
- I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
- It should be made absolutely clear that the physician, staff or representatives of this center are neither providing medical cannabis, nor are they encouraging any illegal activity in my obtaining or using medical cannabis.
- Furthermore, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold the physician, the staff or any agents of this center free and harmless of any liability resulting from the use of medical cannabis.

I have read, understood and affirm all of the above statements.

X _____ **Date:** _____

Arkansas Progressive Medicine
1000 East Matthews, Suite E
Jonesboro, AR 72401
(870) 520-6007

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from designated third-party payers
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on the consent.

Patient's Name

DOB: (mm/dd/yy)

Signed (Patient or Legal Rep for the Patient)

Date:

Legal Representative's Relationship to Patient