Midori Med

New Patient Intake

Thank you for your interest in our clinic. During your first visit, you'll be required to supply us with a valid Florida driver's license or state ID card. If you do not possess a valid Florida driver license or Florida identification card, you may submit a copy of a utility bill in your name including a Florida address, or a Florida voter registration card. For minor patients, the parent or designated legal representative must submit proof of residency of the parent or designated legal representative.

To streamline your initial appointment, we ask that you print, read, and complete each form within this packet prior to your scheduled visit.

We would like to see your most current medical records from the last 12 months. You can ask your current primary care physician or specialist to fax or mail us a copy of your records. Our fax number is 786-463-1670. You can print and complete our medical records form included within this packet and give it to your current doctor. Note that your doctor's office may charge you to send us records. We can also complete a records release and fax it to your doctor from our office the day of your visit.

If you are unable to complete or print this packet at home, you'll need to fill out all this information prior to being seen by the doctor. Please call us at 754-777-8283 or email us at help@midorimed.com if you have questions or issues.

Medical Marijuana Acknowledgment of Disclosure and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree with the information regarding the risks and side effects of using Medical Marijuana[1]. Do not sign this agreement and do not use Medical Marijuana if you have questions about or do not understand the information you have received. Please tell us if you do not understand any of the information provided.

Patient Name_____ DOB____/_____/_____

Address_____

City_____, FL Zip Code_____

Physician Obtaining Consent: Dr. Bruce S. Rubinowicz, D.O.

Physician Signature  Date_____/_____/_____

Warnings/Disclosure

____I understand that possession or use of Medical Marijuana is unlawful under Federal law and outside of the state of Florida. I also understand that possession or use of Medical Marijuana is unlawful within the state of Florida if not recommended for medical purposes by a licensed medical doctor with the legal ability to do so.

____Certain forms of Medical Marijuana may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration and was produced without FDA oversight for health, safety, or efficacy. Medical Marijuana may contain unknown quantities of active ingredients, impurities, or contaminants.

[1] "Medical Marijuana" has the meaning given "Medical cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2016) "Medical cannabis" means all parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, sale, derivative, mixture or preparation of the plant or its seeds or resin that is dispensed only from a dispensing organization for medical use by an eligible patient as defined in Section 499.0295, Florida Statutes (2016)

____The efficacy and potency of Medical Marijuana may vary widely depending on the strain and ingestion method.

____If Medical Marijuana is vaporized: Such use may be hazardous to your health. Medical Marijuana contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.

____If Medical Marijuana is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten, or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.

____There is limited information on the side effects of using Medical Marijuana, and there may be associated health risks.

____Symptoms of Medical Marijuana overdose include but are not limited to nausea, vomiting and disturbances to heart rhythm.

____For some patients, chronic Medical Marijuana usage can lead to laryngitis, bronchitis, and general apathy.

____I understand side effects of Medical Marijuana can include but are not limited to:
Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, Poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation

____The scientific basis for the medical use of Medical Marijuana is not complete. There is little known regarding how Medical Marijuana may, or may not, react with other pharmaceutical or herbal medications.

____Some patients can become dependent on Medical Marijuana. This means they experience withdrawal symptoms when they stop using Medical Marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

____Some users develop a tolerance to Medical Marijuana. This means higher and higher doses are required to achieve the same symptom relief.

Medical Marijuana Patient Agreement

____I am over 18 years of age and understand the requirements of the State of Florida's Medical Marijuana program.

____I have been advised of the current state of knowledge in the medical community of the effectiveness of Medical Marijuana for the treatment of my condition.

____I have been advised of the potential risks and side effects of using Medical Marijuana.

____I have been advised of the medically acceptable alternatives [as set forth in Addendum A]: FOR PATIENTS WHO HAVE ESTABLISHED THEIR 90 DAYS ONLY!

____I have read and understand the foregoing disclosures and have initialed next to each to acknowledge this understanding.

____I have been further advised that some forms of Medical Marijuana may contain chemicals known as tars that may be harmful to my health.

____I understand that side effects may occur while I am taking Medical Marijuana.

____If I experience an adverse reaction, I am advised to contact my medical professional. In the event my medical professional is not available, I agree to call 911 for help and I am advised to lie down, relax, and rest until help arrives.

____I have never had symptoms of schizophrenia or have been diagnosed as having schizophrenia by a physician or mental health professional.

____I have no direct blood relatives (father, mother, siblings) that have had symptoms or has been diagnosed as having schizophrenia or has been psychotic.

____I agree to tell my medical professional if I have ever had symptoms of schizophrenia, been psychotic or attempted suicide. I also agree to tell my medical professional if I have ever been prescribed or taken medicine for any of these problems.

____I understand that my medical professional does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

____I am not pregnant, intending on becoming pregnant, or breastfeeding.

____When under the influence and/or in possession of Medical Marijuana in public, your state issued Medical Marijuana ID Card or temporary state issued verification should be on your person always.

____I understand if I give dishonest or untruthful information, I will be discharged.

____I understand I must give 48-hours' notice for cancellation of appointments. I further understand that 2 or more no calls/no shows within a calendar year will result in my discharge from the practice as well as possible revocation of patient recommendation.

____I understand there are certain requirements to remain in compliance with Florida law regarding Medical Marijuana. Some of these requirements include (but are not limited to):

- Regularly scheduled follow-ups at intervals determined by state law

____I understand that the Department of Health may revoke a Compassionate Use Registry identification card for any of the following:

(a) The patient or legal representative makes material misrepresentations in his or her application.

(b) The patient uses his or her card to obtain cannabis for another individual

(c) The legal representative purchases, obtains, possesses, or uses cannabis not sold by an approved dispensing organization, or

(d) The patient is no longer a qualified patient.

____I further understand that if I am not in compliance with state law and regulations set fourth and enforced by the Office of Compassionate Use, my order may be revoked.

____I understand and acknowledge that my patient information must be provided to the Office of Compassionate Use and that my treatment plan (and follow-up treatment plans) must be provided to the University of Florida's College of Pharmacy by state law.

____If I start taking Medical Marijuana, I agree to tell my medical professional if I experience (any one or more of the following): Start to feel sad or have crying spells Have changes in my normal sleep patterns Lose my appetite. Become more irritable than usual Become unusually tired Withdraw from family and friends Lose interest in my usual activities

Release of Liability

I hereby acknowledge Midori Med, and its employees are not addressing specific aspects of my medical care nor are any of them my primary care provider. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Midori Med, and its 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.

I certify that I fully understand the potential risks and side effects related to the use of Medical Marijuana as described above.

In using Medical Marijuana, I fully accept responsibility and assume the risks and side effects associated with its use.

I agree that Midori Med and its employees shall not be held responsible for any harm resulting to me and/or any other individual(s) because of my use of Medical Marijuana.

I certify that I have read this document and declare under penalties of lying under oath that the information contained herein is true, correct, and complete.

Patient [or legal guardian] Signature: _____ Date _____

Printed Name: _____