207 N. 14th Street
Jeannette, PA 15644
T: 855-502-2273
F: 724-578-3256
www.recoverycare.org

Thank you for your interest in our clinic. During your first visit, you'll be required to supply us with a valid Pennsylvania driver's license or state ID card. If you do not possess a valid Pennsylvania driver license or Pennsylvania identification card, you may submit a copy of a utility bill in your name including a Pennsylvania address, or a Pennsylvania 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.

The forms and paperwork included are:

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 724-578-3256. 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 of this information prior to being seen by the doctor. Please call us at 855-502-2273 or email us at heather@recoverycare.org if you have questions or issues.

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Medical Marijuana Acknowledgement 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. 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's Name_____

DOB _____

Address_____

City _____ Zip Code _____

Physician Signature: _____

Date _____

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I am being evaluated for a physician's order for Medical Marijuana. The physician will make this order based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical 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 Medical Marijuana. I have been informed of and understand the following:

I understand that possession or use of Medical Marijuana is unlawful under Federal law and outside of the state of Pennsylvania. I also understand that possession or use of Medical Marijuana is unlawful within the state of Pennsylvania 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. The efficacy and potency of Medical Marijuana may vary widely depending on the strain and ingestion method.

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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

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appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, and 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.

The possibility exists that Medical Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. Women should not consume Medical Marijuana while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice or the infant's pediatrician.

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Using Medical Marijuana while under the influence of alcohol is not recommended. The use of Medical Marijuana may affect coordination, cognition, and judgment. While under the

influence of Medical Marijuana, do not to drive, operate machinery, or engage in potentially hazardous activities. Please note that Medical Marijuana will degrade over time. Always keep out of reach of children and pets.

Medical Marijuana Patient Agreement

_____ I am over 18 years of age and understand the requirements of the State of Pennsylvania'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 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.

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_____ In the event that 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.

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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 at all times.

_____ 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 Pennsylvania law regarding Medical Marijuana. Some of these requirements include (but are not limited to):

• Patient establishment within our practice for 90 days

• 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.

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(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 forth and enforced by the Pennsylvania Department of Health Marijuana Program, my order may be revoked.

_____ 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

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- Lose interest in my usual activities

Release of Liability

I hereby acknowledge Recovery Care LLC 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 Recovery Care LLC, 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.

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

I agree that Recovery Care LLC, and 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 perjury that the information contained herein is true, correct, and complete.

Patient's (or legal guardian's) Signature: _____

Date: _____

Printed Name:

Name: _____

First, M, Last

DOB: _____

Address _____

City, ST. Zip: _____

Phone: Cell: _____

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Email: _____

Medical Release of Information

I, (_____)

Date: _____/_____/_____,

BIRTHDATE _____

SOCIAL SECURITY # _____

Authorize

(Doctor Name) _____

(Doctors Phone or Fax Number) _____

to release and discuss any and all medical records and medical information that you have for me in your possession regarding my medical condition and my medical treatment, including but

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not limited to, my medical history, my medical treatment, your findings regarding my medical condition, records of consultations that I have had, records of medication prescribed for me, x-rays taken of me, my radiology reports, and hospital, and medical records to:

Recovery Care LLC

207 N. 14th Street

Jeannette, PA 15644

Fax: 724-578-3256

Tel: 855-502-2273

for the sole purpose of medical records review and certification of my medical condition.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is intended to be an unlimited, full, and complete Authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and

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Accountability Act of 1996 (HIPAA) and the Medical Records Access Act, as amended, and under the rules and regulations thereof, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. A covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b) (4) applies. It is understood that the person to whom this Authorization is given has my permission to use and disseminate this information in his or her sole discretion.

1. Expiration. This authorization expires 18 months after patient signed this release.

2. Right to Revoke. I have the right to revoke this authorization by signing and dating a written statement revoking this authorization, and it shall become effective on delivery to you. If this authorization is revoked, any person or entity acting in good faith in reliance upon it and lacking actual knowledge of its revocation shall be held harmless.

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3. Re-disclosure. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this rule.

4. Administrative Provisions. I revoke any prior authorizations I have made to disclose health information that are inconsistent with this authorization. This document shall be governed by Pennsylvania law, the Health Insurance

Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191, and the Medical Records Access Act, MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Pennsylvania law and HIPAA to interpret and determine the validity and enforceability of this document.

Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I am at least 18 years old.

Cancellation/No Show Payment Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we were unable to schedule you for a visit, due to a full schedule.

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Cancellations

It is our policy that all appointments must be cancelled at least 48 hours in advance of the appointment. If an appointment is not cancelled 48 hours in advance, you will be charged the full appointment cost. Your credit or debit card on file will automatically be charged on the day of the cancellation if you are cancelling less than 48 business hours prior to your appointment. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for late cancellations.

No Show

Patients who "No Show" their visit will be charged for that visit, AND will need to prepay future appointments. Your credit or debit card on file will automatically be charged on the day you "No Show" your appointment. All patients will have the opportunity to show proof of an "urgent'' reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for not showing for their scheduled appointment.

Follow Up Visits

Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider. Patients who miss the scheduled follow up visits will be charged the $60 for the missed appointment

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Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We request you come 30 minutes early to your appointment to account for traffic and to complete the required paperwork. If you are 15 minutes past your scheduled time, your provider may not be able to complete a full visit or we will do our best to accommodate you and fit you into the schedule later in the day. If you cannot complete your visit you will be charged for the full visit and you will be required to book a new visit.

Account Balances

We will require that patients pay their account balances to zero (0) prior to receiving further services by our practice. We also require payment be rendered prior to services.

Acknowledgement of Receipt of Cancellation/No Show Policy

I, _____ do hereby acknowledge receipt of a copy of the Cancellation and No Show Payment Policy of Recovery Care LLC.

Signature: _____ Date:_____

Authorization To Charge My Credit/Debit Card

I, _____ authorize Recovery Care LLC to keep my credit/debit card information on file and charge my credit/debit card in the event that I do not cancel my appointment with a 48 business hour notice OR no show for my scheduled appointment(s).

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Signature: _____
Date:_____

Patients not authorizing Recovery Care LLC to keep their credit/debit card information on file will be required to prepay all follow-up and recertification visits.

Your Rights

HIPPA Privacy Statement

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

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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 12 months.

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.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information.

• 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/.

• We will not retaliate against you for filing a complaint.

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.

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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

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

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

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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.

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.

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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.

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, and in our office.

Effective Date

The effective date of this Notice is March 5, 2018.