Toll Free: (888) 985 - 2727 • Fax: (609) 567 – 8832

This Packet is ONLY for Medicinal Marijuana Program (MMP) in NJ

Note: The registry ID # and the reference # will be given to you in the office if you are determined to be eligible for MMP after the initial evaluation

Our Commitment to You

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.
- If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that your keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- We are sorry, but due to the high fax volume we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    1. Referral, if required by insurance
    2. Active valid insurance card
    4. Photo ID
    5. MRI films and reports, CT scan films and reports, bone scan reports
    6. EMG reports
    7. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
    8. List of current medications

Financial Policy

- We are committed to providing you with the best possible care.
- We expect that you have an understanding of your responsibilities under your insurance contract with respect to referral and preauthorization requirements as well as your deductible, co-pay, and coverage limits.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans with which we participate, we will bill your insurance company along the guidelines of our contract. However, we require that **all co-pays or deductibles be paid at the time of service.**
- If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you directly any amount due.
- Returned cheks will be subject to **an additional $25 service fee**.
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.

I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for this account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

_____ X _____ _____

Patient Name Signature Date

Medicinal Marijuana Program (MMP) Disclaimer

I wish to participate in the Medicinal Marijuana Program (MMP) with Relievus. I understand and acknowledge that Medical Marijuana is **not** covered by either federal or private payors and that my personal healthcare insurance will not cover medical marijuana claims.

Thus, I agree **not** to make a claim for MMP treatment with my personal healthcare insurance carrier and further agree and acknowledge that **I must pay by cash or major credit card** all related healthcare costs related to the MMP program with Relievus.

By signing below, I accept and acknowledge that I am opting out of using my healthcare insurance for the MMP program and accept paying cash or major credit card for these services.

Acknowledged and accepted by:

Patient Name

Patient Signature Date

MEDICINAL MARIJUANA PROGRAM (MMP) in NJ

Guidelines for Patients and Caregivers

- As a new participants in the Medicinal Marijuana Program (MMP), we would like to provide you with guidelines to help ensure your compliance with the New Jersey Compassionate Use Medicinal Marijuana Act (CUMMA). Your adherence to these guidelines will minimize the risk of problems in the event you encounter law enforcement while in possession of medicinal marijuana or paraphernalia. The Attorney General is promulgating guidelines to the relevant law enforcement agencies in New Jersey regarding the enforcement of CUMMA. Law enforcement officers will be trained to respect CUMMA, but they will also be trained to make certain that CUMMA is not used to conceal the unauthorized use, possession or distribution of marijuana or other illegal controlled substances.
- Patients and caregivers should **always carry proper identification**, including MMP cards, **at all times**.
- Medicinal marijuana always should be maintained in its **original labeled packaging**.
- Patients should keep medicinal marijuana at their residence and only transport it when absolutely necessary. Understand that the smell of burning or raw marijuana outside a home will attract law enforcement attention.
- If transporting or possessing medicinal marijuana outside their residence patients and caregivers should keep the amount in their possession to a minimum and, as stated above, always should be maintained in its original packaging.
- Patients and caregivers are **not** allowed to share, or in any other way re-distribute medicinal marijuana to any other person. Medicinal marijuana is intended **solely for the consumption of the patient**.
- Patients may possess paraphernalia, but only for the purpose of consuming medicinal marijuana.
- Patients and caregivers may **not** grow or cultivate marijuana, or be in possession of a marijuana plant.
- Patients and caregivers may **not** possess marijuana obtained from a source other than a New Jersey ATC.
- Patients may **not** operate a motorized vehicle (of any sort), aircraft, railroad train, stationary heavy equipment or a vessel while under the influence of medicinal marijuana.
- Patients are encouraged to use medicinal marijuana **only in their residence**.
- Patients may **not** smoke medicinal marijuana in a school bus, on public transportation, or in a private vehicle while in motion. Additionally, patients may **not** smoke medicinal marijuana on any school grounds or at any correctional facility, public park, beach, recreation center, or other place where smoking is prohibited.
- Patients and caregivers may **not** take medicinal marijuana across state lines.
- Patients or a primary caregiver in possession of unwanted marijuana shall dispose of the marijuana by returning it to an alternative treatment center. The person returning the marijuana for disposal should present a valid registry identification card, a New Jersey driver's license or other State-issued photo identification to the ATC or the police.
- All patients and caregivers should be cooperative and truthful at all times with law enforcement; to the extent they encounter them while in possession of medicinal marijuana or paraphernalia.
- You should review these guidelines prior to using or transporting medicinal marijuana. Please contact the MMP Customer Service Unit if you have any questions.

_____ X _____ _____

Patient Name Signature Date

MEDICINAL MARIJUANA PROGRAM (MMP) in NJ

MEDICAL MARIJUANA ACKNOWLEDGEMENT Of DISCLOSURE AND INFORMED CONSENT

1. I, _____ 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:
    - Amyotrophic lateral sclerosis
    - Multiple sclerosis
    - Terminal cancer
    - Muscular dystrophy
    - Inflammatory bowel disease, including Crohn's disease
    - Terminal illness, if the physician has determined a prognosis of less than 12 months of life.
    - Seizure disorder, including epilepsy
    - Intractable skeletal muscular spasticity
    - Glaucoma
    - Post-Traumatic Stress Disorder (PTSD)
    - The following conditions apply, if severe or chronic pain, severe nausea or vomiting, cachexia or wasting syndrome **results from** the condition or treatment thereof: Positive status for human immunodeficiency virus, Acquired immune deficiency syndrome, Cancer
2. I understand that medical marijuana use for treatment of these conditions has not been approved by the Federal Drug Association ("FDA")
3. I have been advised and understand that the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that could impair my ability to drive, operate heave machinery, or engage in potentially hazardous activities.
4. Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer), and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth, and tongue. I have been advised that cannabis (medical marijuana) smoke contains chemicals known' as tars that may be harmful to my health. Vaporizers may substantially reduce many of the potentially harmful smoke toxins that normally present in marijuana smoke.
5. I understand that the side effects may occur while l am taking medical marijuana. These side effects have been explained to me. Side effects of medical marijuana can include, but are not limited to:

Headache	Decreased blood flow to brain	Altered body temperature	Fatigue
Inattention	Aggressiveness	Sedation	Anxiety or panic
Inability to concentrate	Decreased verbal skills	Nystagmus	Decreased coordination
Suicidal ideation	Increased food consumption and weight gain	Rapid heart rate	Reduced muscle strength
Altered libido / Impotence	Hallucinations	Confusion	Paranoia
Euphoria	A motivational syndrome	Increased talkativeness	Hunger
Addictive behaviors	Depersonalization	Reduced testicular size	

6. Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptom s of marijuana overdose include, but are not limited to nausea, vomiting, disturbances to heart rhythms and numbness of the limbs and/or hacking cough
7. For some patients, chronic marijuana over use can lead to laryngitis, bronchitis and general apathy.
8. Using marijuana may decrease reproduction function in men as well as women. Women who are trying to conceive, or who are pregnant or breast-feeding should not use marijuana. Marijuana may increase risk of leukemia in children whose mothers smoked marijuana during pregnancy. Marijuana may also increase risk of an aggressive form of testicular cancer in men.
9. I understand that some patients can become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms, while generally mild, can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbances, unusual tiredness, troubled concentration and/or loss of appetite.
10. Although marijuana does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in persons predisposed to that disorder.
11. I understand that using marijuana while under influence of alcohol is not recommended.
12. 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.
13. I agree to tell the attending physician/nurse practitioner/medical provider if I have ever had symptoms of depression, been psychotic, attempted suicide, or had any other mental problem. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of these problems.
14. I understand that the attending physician/nurse practitioner/medical provider does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.
15. I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis (medical marijuana) provides substantia l relief and improvement in my condition.
16. If I start taking medical marijuana, I agree to tell my attending physician/nurse practitioner/medical provider if I experience any adverse symptoms (side effects).
17. I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and may contain unknown quantities of active ingredients, impurities and I or contaminants. In requesting an approval or recommendation for the use of this plant as medication I assume full responsibility for any and all risks of this action.
18. I am advised that the use of cannabis 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 I or other individuals as a result of my use of cannabis.
19. Some users develop a tolerance to marijuana. This means higher and doses are required to achieve the same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician.
20. I agree to discontinue its use and report problems or side effects to the attending physician/nurse practitioner / medical provider.
21. I understand that the attending physician/nurse practitioner/medical provider, staff and representatives of this practice are neither providing nor dispensing cannabis, nor are they encouraging any illegal activity in my obtaining medical marijuana.
22. I understand that the attending physician/nurse practitioner/medical provider in order to conduct an appropriate evaluation, must do a physical exam and take my prior medical history and family history. 1 decline examination of my private parts unless I feel it is relevant to my complaints.
23. At this time, cannabis is an alternative or complementary treatment. I understand to receive a recommendation for cannabis use, I should have tried, or be willing to consider trying, at least one other recommended treatment from a medical provider. I have obtained or attempted to obtain medical records pertaining to my condition or currently have to medical records pertaining to my condition and agree to be referred for further evaluation as the physician deems necessary.

_____ X _____ _____

Patient Name Signature Date

Release of All Claims and Liability

- I understand that should I be given a recommendation for medical use of cannabis, I understand that I must be regularly followed- up by a doctor and appear for a re-evaluation at a date specified by the attending physician/nurse practitioner / medical provider .
- I request a consultation by an attending physician/nurse practitioner/medical provider for the sole purposes of determining the appropriateness of medical cannabis treatment. I, the undersigned, understand that there are no representations about the medical efficacy of cannabis.
- I understand that the attending physician/nurse practitioner/medical provider, staff, and representatives at Relievus – Advanced Spine and Pain, LLC are addressing specific aspects of my medical care, and, unless otherwise stated are in no way establishing themselves as my primary care provider. The attending physician/nurse practitioner/medical provider is only rendering an opinion regarding the therapeutic indication of the use of medical marijuana.
- My heirs, assigns, or anyone acting on my behalf, hold the attending physician/nurse practitioner/medical provider and his/her principles, agents and employees, free of and harmless from any responsibility and liability resulting from the use of cannabis. In case any claim or dispute arises, I agree to arbitrate such claims/disputes and I agree that New Jersey law will govern such claims/disputes.
- Further, if any of these clauses is deemed invalid, the other clauses will remain in full force and effect.

_____ X _____ _____

Patient Name Signature Date

What debilitating medical conditions are approved by the program?

- A physician must certify that a patient has an approved debilitating medical condition to participate in the Medicinal Marijuana Program. Approved debilitating medical conditions include:
  - □ **Amyotrophic lateral sclerosis**
  - □ **Multiple sclerosis**
  - □ **Terminal cancer**
  - □ **Muscular dystrophy**
  - □ **Inflammatory bowel disease, including Crohn's disease**
  - □ **Terminal illness, if the physician has determined a prognosis of less than 12 months of life.**
  - □ **Seizure disorder, including epilepsy**
  - □ **Intractable skeletal muscular spasticity**
  - □ **Glaucoma**
  - □ **Post-Traumatic Stress Disorder (PTSD)**
  - □ **The following conditions apply, if severe or chronic pain, severe nausea or vomiting, cachexia or wasting syndrome results from the condition or treatment thereof: Positive status for human immunodeficiency virus (HIV), Acquired immune deficiency syndrome (AIDS) and Cancer**

- **The physician-patient relationship has existed for at least one year; or**
- **The physician has seen and/or assessed the patient for the debilitating medical condition on at least four visits; or**
- **The physician assumes responsibility for providing management and care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians reflecting the patient's reaction and response to conventional medical therapies.**

MEDICINAL MARIJUANA PROGRAM (MMP) in NJ

Find an Alternative Treatment Center

Compassionate Care Foundation, Inc.	**100 Century Drive Egg Harbor Twp., NJ (609) 277-7547**
Greenleaf Compassion Center	**395 Bloomfield Ave Montclair, NJ 07042 (973) 337-5670**
Garden State Dispensary	**950 U.S. Highway 1 North Woodbridge, NJ 07095 (848) 999-2005**
Breakwater Alternative Treatment Center	**2 Corporate Drive Cranbury, NJ 08512 (732) 703-7300**
Foundation Harmony	**Location Pending (201) 840-5800**
Compassionate Sciences, Inc.	**111 Coolidge Avenue Bellmawr, NJ 08031 (856) 933-8700**

Change My Alternative Treatment Center

- Patients can choose any ATC regardless of where they live. There is no cost to change your ATC registration and it does not require a new identification card, but patients can only be registered with one ATC at a time.
- It is very important patients verify that your 30-60-90 day certification period, approved by your physician, is current and up to date. Expiration dates can be found on your profile by selecting the option to view 30-60-90 certification or by contacting your MMP approved physician.
- If you choose to register with a new ATC you must follow these instructions:
  - ✓ **Go to njmmp.nj.gov**
  - ✓ **Select 'Change ATC'**
  - ✓ **Enter the information used to register along with your reference number (this is not case sensitive)**
  - ✓ **Click the drop down box and select the ATC of your choice**
  - ✓ **Click Save**
  - ✓ **If successfully completed the following message will appear in red: "Your record was successfully updated with new ATC information."**
- Any questions relating to the new ATC can be directed to the ATC's customer service department or by visiting their website.

MEDICINAL MARIJUANA PROGRAM (MMP) in NJ

Caregivers

What is a Caregiver?

- A patient certified for medicinal marijuana may elect to have a caregiver if needed. A caregiver can be used if a patient's condition is too severe to the point where they cannot physically go to their alternative treatment center (ATC) by themselves.
- A caregiver can purchase medicinal marijuana from an ATC without the patient's presence.
- Caregivers are chosen by the certified patient; usually a friend or family member. Caregivers can be added at any time during registration and must go through the same process as patients to receive a card.
- Caregivers are required to submit fingerprints for a criminal background investigation. The fingerprinting forms will be available once the caregiver has begun the online registration.
- Please see the "Do I qualify" information on the left to view if you are eligible to become a caregiver.
- There is a fee of $200 for a caregiver identification card, unless the caregiver is qualified for government assistance (see below) the fee is $20. In addition, there is a fee to have your background check processed.

I was asked to become a caregiver for the MMP, what do I need to register?

- To register for the MMP you must have the following documentation digitally scanned into a computer and uploaded into our secure online registry:
- **Image of yourself**
  - ✓ Photograph must be a recent digital photo taken against a white background; the patient/caregiver shall not wear a hat, glasses or any other item that may alter or disguise the overall features of the face; the patient/caregiver face must take up 70 percent of the picture; and a digital photograph must be in JPEG or GIF format, which is the format currently used by most digital cameras.
- **Government Issue photo identification** - One of the following;
  - ✓ Current NJ digital license
  - ✓ Current NJ digital non-driver ID card
  - ✓ NJ County ID Card
- **Proof of current New Jersey residency - (P.O. Boxes NOT Accepted)** - One of the following:
  - ✓ Utility bill issued in the past 90 days that shows your name at your current address
  - ✓ Utility Bills accepted: Gas-Electric-Water-Sewer-Cell Phone-Cable (Television/Internet/Phone)
  - ✓ Any correspondence from IRS or NJ State tax office within the last year
- ✓ **Proof of government assistance – Optional** - One of the following:
  - ✓ NJ Medicaid
  - ✓ Food Stamp Benefits
  - ✓ NJ Temporary Disability Insurance benefits
  - ✓ Supplemental Security Income (SSI) benefits
  - ✓ Social Security Disability (SSD) benefits

Government assistance pictures for comparison

  - ✓ You will also be required to print out a Criminal Background Investigation Form. This form will be accessible once you are within our registry. This form will contain instructions on where you can sign-up to have your fingerprints taken to clear you as an MMP caregiver.
  - ✓ You will be processed with your accompanied patient and will receive your notice of verification via email once your background check and uploaded documents have been successfully cleared.

MEDICINAL MARIJUANA PROGRAM (MMP) in NJ

Note: The registry ID # and the reference # will be given to you in the office if you are determined to be eligible for MMP after the initial evaluation

Is there a fee to register for NJ State MMP (NJ Online registration for MMP, not for the office visits) ?

- Yes. The fee for patients and caregivers is **$200 each.** Patients and caregivers who qualify for the below listed state and federal assistant programs, will be eligible to pay a fee of **$20 each**; registration period is valid for 2 years.
  - ✓ NJ Medicaid Program
  - ✓ Current Food Stamp Benefits Card
  - ✓ NJ temporary disability insurance benefits
  - ✓ Supplemental Security Income Benefits (SSI)
  - ✓ Social Security Disability Benefits (SSD)

How do I pay my registration fee for NJ State MMP ?

- Once you have received your confirmation email stating your registration fee has been set, you will return to the registry at, **njmmp.nj.gov**, and select the option on the left hand side that says **'Payment'.** You will then have to enter your information including reference number and submit. Follow the instructions to proceed with your payment.

What is a <u>bona fide physician-patient relationship</u>?

- **A bona fide relationship is defined as: a relationship in which the physician has ongoing responsibility for the assessment, care and treatment of a patient's debilitating medical condition whereby:**
  - ✓ **The physician-patient relationship has existed for at least one year; or**
  - ✓ **The physician has seen and/or assessed the patient for the debilitating medical condition on at least four visits; or**
  - ✓ **The physician assumes responsibility for providing management and care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a <u>personal review of the patient's medical record maintained by other treating physicians</u> (Oncologists, PCPs, Infectious Disease physicians, Psychiatrists, Neurologists, Gastroenterologists, Ophthalmologists, etc.) reflecting the patient's reaction and response to conventional medical therapies.**

Where will a qualifying patient be able to smoke medical marijuana?

- The Department notes that smoking medicinal marijuana falls within the definition of "smoking" as set forth in the Smoke Free Air Act at N.J.S.A. 26:3D-57, and is therefore subject to the provisions of the Smoke Free Air Act.
- Patients may not Operate, navigate, or be in control of any vehicle, aircraft, railroad train, or stationary heavy equipment vessel while under the influence of marijuana.
- Patients may not smoke medicinal marijuana On a school bus or public form of transportation.

- In a private vehicle unless the vehicle is not in operation.
- On any school grounds, in any correctional facility, at any public park or beach, at any recreation center.

How much medicinal marijuana can I get approved for?

- Medical marijuana will be packaged in 1/4 ounce denominations. The patient's physician will determine the proper dosage; however, the maximum amount allowed by law is 2 ounces in a 30 day period.

Can I switch my Alternative Treatment Center?

- Yes. You may switch to any operational ATC online at any time. In order to successfully switch to your ATC of choice, you must return to http:// njmmp.nj.gov, and select the option 'Change ATC/View ATC Visits' You will then enter your active patient ID number located on your ID card or you can enter your information as on your attending physician statement.

Do I have to be registered with a specific ATC to purchase medicinal marijuana or can I go to any ATC provided I'm an approved MMP cardholder.

- You must be registered with a specific ATC to purchase your medicinal marijuana. An ATC will not be able to see your information in the system if you are not registered with them.

If my ID card is lost, stolen, or is damaged what do I do and is there a fee to replace the card?

- If a registered patient or registered primary caregiver becomes aware of the theft, loss or destruction of his or her registry ID card, he or she shall notify the MMP within 24 hours after the discovery of the occurrence of the theft, loss, or destruction. The fee to apply for issuance of an ID card replacement is $10.00. If you receive government assistance, and it was verified and approved upon registration, you will qualify for a fee of $5.00.

If I add a caregiver after registering with the MMP, do I need to get a new ID card?

- Yes. To add a caregiver after you have already been approved for the program, you will visit http://njmmp.nj.gov/ and select "Patient Registration". You must return your original MMP ID card to us by certified mail, because you will be issued a new card with your caregiver information on it. Once the caregiver is approved, they will be required to pay the registration fee of $200 or $20, if eligible for government assistance. Your caregiver's effective period will begin upon their approval date and expire with the patient's listed expiration date, regardless of the two year period.

When my 30, 60, or 90 day certification for medicinal marijuana expires, do I have to re-register with the program?

- No. Patient registration is valid for 2 years. However, upon expiration of your 30, 60, or 90 day certification, your physician must re-assess your condition and determine whether to continue your authorized use of medicinal marijuana for an additional 30, 60, or 90 day period. The physician will be required to log into the registry and update your physician statement.

If my 30, 60, or 90 day certification is expired, will I be able to purchase medicinal marijuana?

- No. A patient must have a current certification in order to make an appointment or purchase medicinal marijuana at their Alternative Treatment Center.

PATIENT INFORMATION

Last Name: _____First Name: _____ SEX: M F

If patient is a minor, name of parent or guardian accompanying patient:_____

Relationship to patient: _____Phone # (if different): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ SS#: _____

(Circle one) Married Single Divorced Widowed Other

Referred by: _____ Phone: _____Location: _____

Family Doctor: _____ Phone: _____Location: _____

INSURANCE

Primary Insurance Name: _____

ID #: _____Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Secondary Insurance Name: _____

ID #: _____Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Emergency Contact: _____Phone: _____

Are we authorized to release your medical information to the listed emergency contact? Yes or No

SIGNATURE: _____ DATE: _____

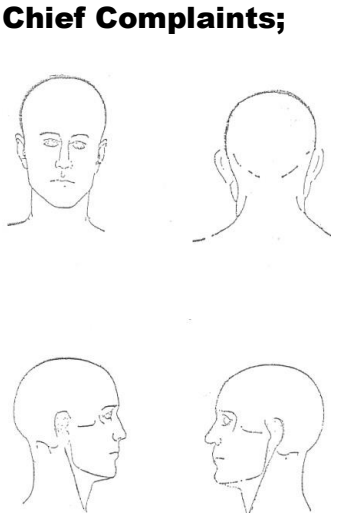
• Today's date: _____ • Name : _____

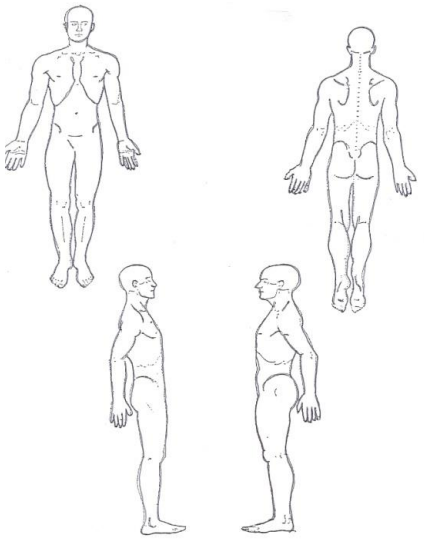
• Age_____ • Date of Birth _____ • Height _____ • Weight _____

□ Right hand dominant □ Left hand dominant • Sex : □ Male □ Female

Referral Physician: _____ **Primary Care Physician:** _____

Chief Complaints;





• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

Check all eligible diagnoses for Medicinal Marijuana Program (MMP) in NJ

□ Amyotrophic lateral sclerosis □ Muscular dystrophy □ Multiple sclerosis

□ Seizure disorder, including epilepsy □ Inflammatory bowel disease, including Crohn's dz

□ Terminal cancer (Name of the cancer: _____)

□ Terminal illness, if the physician has determined a prognosis of less than 12 months of life.

□ Intractable skeletal muscular spasticity □ Glaucoma □ Post-Traumatic Stress Disorder

□ Positive status for human immunodeficiency virus □ Acquired immune deficiency syndrome

• Location _____

_____

_____

- Does the pain radiate anywhere (“shooting down” or “shooting up”)

_____

- When was the pain started ? _____

_____

- How was the pain started ? _____

_____

- Please, describe your pain

□ Dull □ Aching □ Sharp □ Shooting □ Stabbing □ Throbbing □ Numbness □ Burning

_____

_____

- How often is your pain present ? □ Occasional □ Frequent □ Constant
- Worst time of day? □ Morning □ Afternoon □ Evening □ Night □ All the time
- Any color change or temperature change? _____
- Numbness in anywhere? _____
- “Pins and needles” ? _____
- Weakness? (Right leg, right arm, both legs….) _____
- Swelling ? _____
- What makes symptoms worse/exacerbate? _____
  □ Walking □ Standing □ Lying down □ Sitting □ Bending forward □ Bending backward □ Driving
  □ Coughing □ Bowel movement □ Cold weather □ Hot weather □ Rainy day □ Lifting objects
- What makes the symptoms better ? _____
  □ Resting □ Massage □ Exercise □ Sitting □ Lying down □ TENS unit □ Physical therapy
  □ “Injections” □ Sleeping □ Medication (Names) _____ □ Other _____
- Sleeping : □ Well □ “OK” □ Terrible □ 2 hrs □ 4 hrs □ 6 hrs □ 8 hrs □ >10 hrs
- How often do you wake up at night? □ 0 □ 1 □ 2 □ 3 □ 4 □ >5 times

Previous Treatments

Physical therapy □ Location _____ □ Date of Last PT _____ □ Duration _____

Acupuncture _____ Psychotherapy _____

Chiropractor _____ Other (Biofeedback, Meditation, Yoga, Swimming)

TENS Unit ☐ Never used ☐ I have a unit ☐ I don't have one ☐ Used at home daily ☐ Used at home as needed ☐ Used during PT

Previous "injections"

□ Epidural	_____	_____	_____
	Date	Number of injection	Doctor's name
□ Facet	_____	_____	_____
	Date	Number of injection	Doctor's name
□ Nerve block	_____	_____	_____
	Date	Number of injection	Doctor's name
□ Joints	_____	_____	_____
	Date	Number of injection	Doctor's name
□ Others	_____	_____	_____
	Date	Number of injection	Doctor's name

Review of System

- Gen □ Weight loss □ Weight gain □ Fever □ Fatigue □ Loss of appetite □ Nausea □ Vomiting
- Skin □ Skin problem □ Rash □ Psoriasis □ Slow healing □ Easy bruising □ Itching
- Neuro □ Light headed/dizziness □ Fainting □Weakness □Stroke □ Tremor □ Seizure □ Memory loss
- Eyes □ Vision problem □ Glaucoma □ Blurred vision □ Double vision
- ENT □ Ear pain □Hearing loss □Ear noises □Nose bleed □Sore throat □Hoarseness □Dental issues
- Cardiovascula □ Chest pain □Chest pressure □Shortness of breath □Irregular heart beat □ Murmurs
- Respiratory □ Coughing □ Difficulty breathing □ Asthma/Wheezing □ Coughing up blood
- Gastrointestinal □ Constipation □ Diarrhea □Heartburn □Bloody stool □Pain in stomach □Ulcers □Hepatitis
- Genitourinary□ Painful urination □Frequent urination □Bloody urine □Kidney stone □Incontinence □ Sexual difficulty □ Infection
- Endocrine □ Hypothyroidism □ Hyperthyroidism □ Diabetes □ Parathyroid problems
- Hematology □ Anemia □ Bleeding disorder □ Easy bleeding □ Lymphoma/Leukemia □ Sickle cell disease
- Immunologic □ Catch cold easily □ HIV/AIDS □ Fever □ Hay fever □ Frequent sinus problems □ Allergies
- Musculoskeletal □ Arthritis □Rheumatoid arthritis □Osteoarthritis □Compression fracture □Head injury □ Neck injury□ Lower back injury □ Spinal trauma □ Birth trauma □ Birth defect □ Lupus □ Spina bifida □ Gout □ Osteoporosis □ Muscular dystrophy □ Muscle pain □ Scoliosis
- Women only □ Irregular periods □ Premenstrual depression □ Hot flashes □ Menstrual cramps □ Vaginal discharge □ Hysterectomy □ Breast surgery □ Nipple discharge □ Breast lumps □ Last mammogram _____
- Men only □ Burning on urination □ Dripping after urination □ Prostate problems □ Difficulty urinating
- Psychiatric □ Depression □ Anxiety □ Panic attacks □ OCD □ Manic □ Bipolar □ Suicidal attempts □ Suicidal ideation □ Homicidal □ Hallucination □ Psychosis □ Other _____

Past Medical History

- Heart ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐ Valvular disease ☐ Aneurysm ☐ High cholesterol ☐ Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other _____
- Lungs ☐ Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other _____
- Gastrointestinal ☐ Ulcer ☐ Reflux ☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other _____
- Kidney ☐ Failure ☐ Stones ☐ Dialysis (When) _____ ☐ Other _____
- Endocrine ☐ Diabetes ☐ Hypothyrodism ☐ Hyperthyroidism ☐ Other _____
- Neuro ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia ☐ Seizures ☐ Parkinson's ☐ Other _____
- Psychiatric ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other _____
- Bone/Muscular ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other _____

• Cancer □ _____

• Other □ _____

Past Surgery History

_____

_____

Allergies

• Latex □ No □ Yes Reaction _____ • Contrast (Dye) □ No □ Yes Reaction _____

• Allergic to any medication(s) ? _____

_____

_____

Previous Medications (Tried previously but failed to relieve the symptoms & pain)

_____

_____

_____

_____

Current Medications

_____

_____

_____

_____

Significant Family History (Cancer, hypertension, diabetes, depression, back pain…)

- Father side _____
- Mother side _____
- Siblings _____

Social History

- Tobacco: □ Never □ Quit in _____ □ Currently ____ pack per day
- Alcohol : □ Never □ Rarely □ Moderate □ Daily_____
- Use of drugs: □ Never □ Occasionally □ Frequently, Type/frequency _____
- Marital status: □ Single □ Married □ Separated □ Divorced □ Widowed
- Family status: Living with _____
- Occupation: _____
- Disability: □ No □ Yes (Type) _____
- Litigation (Lawsuit): □ No □ Yes against _____ working with _____

Radiological studies / Lab studies

- MRI □ Neck _____ (Date) □ Upper back _____ (Date) □ Lower back _____ (Date) □ Other _____ (Date)
- CT □ Neck _____ (Date) □ Upper back _____ (Date) □ Lower back _____ (Date) □ Other _____ (Date)
- EMG □ Arm _____ (Date) □ Leg _____ (Date) □ Other _____

A bona fide physician-patient relationship has to be established.

- **A bona fide relationship is defined as: a relationship in which the physician has ongoing responsibility for the assessment, care and treatment of a patient's debilitating medical condition whereby:**
  - **The physician-patient relationship has existed for at least one year; or**
  - **The physician has seen and/or assessed the patient for the debilitating medical condition on at least four visits; or**
  - **The physician assumes responsibility for providing management and care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians (Oncologists, PCPs, Infectious Disease physicians, Psychiatrists, Neurologists, Gastroenterologists, Ophthalmologists, etc.) reflecting the patient's reaction and response to conventional medical therapies.**

This form is completed by

□ Patient X _____ Date _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Relievus is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Description of information to be released
Check each person/entity that you approve to receive information.

- Voice Mail
  - ☐ Results of lab tests/x-rays
  - ☐ Other_____
- Spouse (provide name & phone number)_____
  - ☐ Financial
  - ☐ Medical as follows:_____
- Parent (provide name & phone number) _____
  - ☐ Financial
  - ☐ Medical as follows:_____
- Other (provide name & phone number) _____
  - ☐ Financial
  - ☐ Medical as follows:_____

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

_____ Date _____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care service. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our web site www.relievus.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when have the necessary permission from you to disclose your protected health information. For example, your protected health information is provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and Disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your physician may, using professorial judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on out professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your

protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situation without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such or disclosures.

Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency got activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit program, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state law.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviation, tract products; to enable product recalls; to make repairs replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purpose include (1) legal processes and otherwise required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises or the practice, and (6) medical emergency (not on practice's premises) and it's likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to reasonable anticipation of death. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purpose.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state law, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected information in the course of providing care for you.
Required Uses and Disclosure: Under the law, we must make disclosure to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Your Rights
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have the decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. **You have the right to request a restriction of your protected health information.** This means you may ask us not or disclose any part of your protected health information for the purpose of treatment, payment or health operation. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by (**describe how patient may obtain a restriction.)**
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purpose. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain; restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____Date _____

MEDICINAL MARIJUANA PROGRAM (MMP)
Patient Registration

Note: The registry ID # and the reference # will be given to you in the office if you are determined to be eligible for MMP after the initial evaluation

- Check-Off List for Qualifying Patients/Caregivers → Go to https://njmmp.nj.gov/ and open Patient Registration page
- Complete required information
- Enter patient reference number supplied by physician and submit
- Complete required patient information
- Enter the Alternative Treatment Center of choice
- Complete patient certification
- Complete required caregiver information (if applicable)
- Click "Save and Continue" and review confirmation page
- Continue to upload documents for both patient and caregiver (if applicable)
- Upload patient and caregiver photograph – Required
    - ✓ Photograph must be a recent digital photo taken against a white background; the patient/caregiver shall not wear a hat, glasses or any other item that may alter or disguise the overall features of the face; the patient/caregiver face must take up 70 percent of the picture; and a digital photograph must be in JPEG format, which is the format currently used by most digital cameras.
- Document 1 - Government issue photo identification – Required one of the following:
    - ✓ Current NJ digital license
    - ✓ Current NJ digital non-driver ID card
    - ✓ NJ County ID Card
- Document 2 - Proof of current New Jersey residency - Required (P.O. Boxes NOT Accepted) one of the following:
    - ✓ Utility bill issued in the past 90 days that shows your name at your current address
    - ✓ Utility Bills accepted: Gas-Electric-Water-Sewer-Cell Phone-Cable (Television/Internet/Phone)
    - ✓ Any correspondence from IRS or NJ State tax office within the last year.
- Document 3 – Proof of government assistance - Optional one of the following:
    - ✓ NJ Medicaid
    - ✓ Food Stamp Benefits
    - ✓ NJ Temporary Disability Insurance benefits
    - ✓ Supplemental Security Income (SSI) benefits
    - ✓ Social Security Disability (SSD) benefits
    - ✓ Government assistance pictures for comparison
- Save and continue
- If applicable, download the caregiver criminal background check form. The Caregiver is required to complete form and follow the attached instructions.
- The MMP will review your application and supporting documents. All applications will be responded to via e-mail with further instructions for finalizing your application. Approved applicants will be instructed on the MMP e-payment process.
- Once notified by the MMP of the fee amount, the patient will be prompted to return to the registry homepage and click on payment (you will need your patient reference number) click submit and complete the required information (as noted by the red asterisk). If submitted correctly, you will receive a transaction confirmation number on the last page.
- Denied applicants will be provided instructions on amending your application.
- Questions regarding this process will be addressed by contacting the MMP Customer Service Unit at 609-292-0424 or medical.marijuana@doh.nj.gov