Notice of Privacy Practices

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations and your rights concerning your Protected Health Information (PHI). We must follow the practices that are described in the Notice or amended version of the Notice.

Permissible Uses and Disclosures Without Your Written Authorization: We may use and disclose PHI without your written authorization for purposes described below. These are examples of the types of PHI disclosures that are permissible under federal and state law.

1. **Health Care Operations:** We may use PHI in connection with our healthcare operations, including quality assurance activities, training programs, accreditation, licensing or credentialing activities.
2. **Required by law:** We may disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may also disclose PHI if necessary, to avert a serious threat to your health or safety, or the health and safety of others. Other disclosures permitted or required by law include disclosures for public health and health oversight activities, including disclosures to state or federal agencies authorized to access PHI, disclosures to law enforcement officials in response to a court order or other lawful process and disclosures to military or national security agencies, coroners, medical examiners and correctional institutions as authorized by law.
3. **Follow-up issues:** We may use and/or disclose PHI to contact you to advise you that we have follow-up information for you. The advice to call us may be left on a telephone answering machine or sent via US mail. We will accommodate reasonable requests that we provide you with this information through alternative means.

Uses and Disclosures Requiring Your Written Authorization:

1. **Marketing Communications.** We must obtain your written authorization prior to using your PHI for marketing purposes. If the marketing involves any financial compensation to us, the authorization must state that such compensation is involved.
2. **Uses and Disclosures of your Highly Confidential Information.** Federal and state law requires special privacy protections for certain highly confidential information about you. This includes PHI that is about:(1) mental health and developmental disability services, (2) alcohol and drug abuse issues, (3) AIDS/HIV testing, diagnosis or treatment, (4) venereal diseases, (5) genetic testing, (6) child abuse and neglect, (7) domestic abuse of an adult with a disability, and or (8) sexual assault. In order for us to disclose this highly confidential information for a purpose other than those permitted by law, we must obtain your written authorization.
3. **Other Uses and Disclosures.** Uses and disclosures other than those described in this notice will only be made with your written authorization. You may revoke such authorization at any time by providing us with written notification of the revocation.

Your Individual Rights:

1. **Right to Inspect and Copy.** You may request access to your medical records and request copies of the records. All requests for access must be made in writing.
2. **Right to Alternative Communications.** We will accommodate any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
3. **Right to Request Restrictions.** You may request a restriction on PHI use for healthcare operations. You must request any such restriction in writing.
4. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us.
5. **Right to Request Amendment.** You may request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended.
6. **Right to Obtain Notice.** You have the right to obtain a paper copy of the Notice.

Signed: ____________________________________________ Date: __________________________

REV. 10/7/19
Do you have a cardiac condition? □ YES □ NO
Do you smoke tobacco? □ YES □ NO
Cigarettes a day
Do you drink alcohol? □ YES □ NO
Drinks a week
Do you use illicit drugs (Non-cannabis)? □ YES □ NO
Cocaine □ Heroin □ MDMA □ Other: _______
Are you currently on/in: □ Methadone, Suboxone, or Vivitrol □ Alcohol withdrawal Management □ Addiction Counseling
Do you have any family history of Psychosis? □ YES □ NO
Do you have any family history of Schizophrenia? □ YES □ NO
Do you have any family history of a major cardiac condition? □ YES □ NO
If so, which condition: __________

(Women) Are you currently pregnant, planning on being pregnant, or breast feeding? □ YES □ NO
LMP Date: _______
Have you had any pain today? (Not including minor pains such as minor headaches, sprains, toothaches) □ YES □ NO

Please list areas where you feel pain:
From 0-10 list the WORST pain in the last 24 Hours: _______
From 0-10 list the LEAST pain in the last 24 Hours: _______
From 0-10 please rate your AVERAGE pain level: _______
From 0-10 please rate your pain level RIGHT NOW: _______
What treatments or medications are you receiving for your pain?:
In the past 24 hours, how much RELIEF have the pain treatments or medication provided? (From 0% to 100%): _______%
From 0-10 how has pain interfered with general activity?: _______
From 0-10 how has pain interfered with your mood?: _______
From 0-10 how has pain interfered with walking ability?: _______
From 0-10 how has pain interfered with normal work?: _______
From 0-10 how has pain interfered with relationships?: _______
From 0-10 how has pain interfered with sleep?: _______
From 0-10 how has pain interfered with enjoyment of your everyday life?: _______

(Staff Only) BPI Severity ______ BPI Interference ______

This visit is limited to an evaluation of your health and medical condition for the purposes of a Medical Marijuana Certification. If you desire any additional medical treatment such as specific dosing with follow up visits, a separate appointment and payment to the office will be required. This is not a dispensary of Medical Marijuana and we are not affiliated with any distributor of cannabis. We do not recommend any patients to a specific distributor or dispensary.

Medical records may be required by the physician. Follow up phone calls may be conducted to complete further evaluations over the phone, patients are not required to participate.

I attest the above information to be true and accurate to the best of my knowledge. I authorize Relaxed Clarity to contact me with the above phone number and email address I provided. I authorize Relaxed Clarity to review my prescription history for the purpose of this evaluation. I understand authorization for a release of this information is required.

Patient Signature: ____________________________  Today’s Date: ____________________________

REV. 10/7/19
1. In general, would you say your health is:

☐ Excellent  ☐ Very good  ☐ Good  ☐ Fair  ☐ Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

   YES, limited a lot  ☐   YES, limited a little  ☐   NO, not limited at all  ☐

3. Climbing several flights of stairs.

   ☐   ☐   ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like.

   YES  ☐   NO  ☐

5. Were limited in the kind of work or other activities.

   ☐   ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like.

   YES  ☐   NO  ☐

7. Did work or activities less carefully than usual.

   ☐   ☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?

   ☐ Not at all   ☐ A little bit   ☐ Moderately   ☐ Quite a bit   ☐ Extremely

These questions are about how you have been feeling during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

9. Have you felt calm & peaceful?

   All of the time  ☐   Most of the time  ☐   A good bit of the time  ☐   Some of the time  ☐   A little of the time  ☐   None of the time  ☐

10. Did you have a lot of energy?

    All of the time  ☐   Most of the time  ☐   A good bit of the time  ☐   Some of the time  ☐   A little of the time  ☐   None of the time  ☐

11. Have you felt down-hearted and blue?

    All of the time  ☐   Most of the time  ☐   A good bit of the time  ☐   Some of the time  ☐   A little of the time  ☐   None of the time  ☐

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

    All of the time  ☐   Most of the time  ☐   Some of the time  ☐   A little of the time  ☐   None of the time  ☐

I attest the above information to be true and accurate to the best of my knowledge. I authorize Relaxed Clarity to contact me at the above phone number and email address I provided. I authorize Relaxed Clarity to review my prescription history for the purpose of this evaluation. I understand authorization for a release of this information is required.

Patient Signature: ___________________________  Today’s Date: ___________________________
Do you have previous cannabis experience? □ YES □ NO (If no, Skip this page)

What kind of strain profile do you prefer to consume?

- THC Dominant THC%________ CBD%________
- CBD Dominant THC%________ CBD%________
- Hybrid THC%________ CBD%________
- Not Sure

How often do you use cannabis?

- Daily
- Weekly
- Monthly
- Past Use

During what time(s) of the day do you use cannabis?

- Morning
- Afternoon
- Evening
- Night

In what method(s) do you use to consume cannabis?

- Topical
- Oromucosal
- Vaporization
- Oil
- Smoking
- Edible

Select the positive effects of cannabis use for you:

- Energetic
- Improved Mood
- Increased Creativity
- Pain Reduction
- Reduced Nausea
- Relaxed
- Euphoric
- Improved Sleep
- Increased Focus
- Reduced Anxiety
- Reduced Seizures
- Uplifted

Other: ______________________

Select the negative effects of cannabis use for you:

- Dizziness
- Fatigue
- Increased Heart Rate
- Drowsiness
- Headache
- Memory Loss
- Dry Eyes
- Increased Anxiety
- Paranoia
- Dry Mouth
- Increased Appetite
- Red Eyes

Other: ______________________

I attest the above information to be true and accurate to the best of my knowledge. I authorize Relaxed Clarity to contact me at the above phone number and email address I provided. I authorize Relaxed Clarity to review my prescription history for the purpose of this evaluation. I understand authorization for a release of this information is required.

Patient Signature: ______________________  Today’s Date: ______________________
Know your Medication and Take the Pledge

Medical cannabis is used in treating debilitating and disabling medical conditions, defined as limiting life activities. Relaxed Clarity and MedEval practitioners and staff are addressing specific aspects of a patient’s medical care. The practitioners and staff are in no way establishing themselves as the primary care provider.

Cannabis potency varies with the strain and the method of consumption. Determining the appropriate cannabis dosage may require a trial and error approach. Always start at the lowest dosage and increase it gradually. The use of cannabis affects coordination and cognition and impairs the ability to drive or engage in potentially hazardous activities. Wait at least six hours after cannabis use before operating any equipment. Smoking cannabis in public or within 1000 feet of a school or daycare is illegal.

Smoking cannabis may cause respiratory illness. Any ill effects experienced with the use of cannabis requires discontinuation of the drug and medical evaluation. Nausea, palpitations and numbness are symptoms of cannabis in excess. Chronic use of cannabis may lead to general apathy in a few patients, or to rare psychosis in those predisposed to the condition (usually in teenagers.) Oral cannabis preparations are less harmful, as are topical products.

Cannabis should not be used if you are pregnant, become pregnant, or if you are breastfeeding. If a reproductive - aged woman uses cannabis, and is not contracepting, she must discontinue cannabis use as soon as pregnancy is recognized.

Some patients may experience symptoms when they stop using cannabis. This includes, but are not limited to, irritability, insomnia, loss of appetite, restlessness, trouble concentrating and fatigue.

Cannabis is not regulated by the Food and Drug Administration and may contain unknown quantities of active ingredients and impurities. Possession of cannabis is still currently illegal under Federal Law. Relaxed Clarity and MedEval practitioners and staff are neither prescribing nor dispensing cannabis. If approved, our certification is that a qualifying medical condition exists and that the potential benefits of medical cannabis appear to outweigh the risks.

TAKE THE PLEDGE
DO NOT CONSUME MEDICINE AND DRIVE!
IMPAIRED DRIVING IS ILLEGAL DRIVING

It is never recommended to use cannabis and operate a vehicle of any kind, regardless of your tolerance or comfort level. The effects of cannabis can affect reaction time, focus, concentration, and the perception of time and distance. Using cannabis and getting behind the wheel of a car could get you arrested for DUI regardless of the current medical or adult use laws in your state! If you’re impaired by drugs, even if they’re legal prescriptions or medical cannabis, you can be arrested for DUI. Always choose the safe way if impaired. It is NOT worth the risks.

I (PRINT NAME)______________________________, AGREE TO NOT MEDICATE AND DRIVE,
I UNDERSTAND THAT CONSUMING MEDICATION AND DRIVING IMPAIRED IS ILLEGAL.

Signed:______________________________ Date:____________________________

Witness:______________________________ Witness Signature:____________________________

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