Green Health and Wellness

111 SE 1st Avenue, Suite 150 (2-A) Gainesville, FL 32601 Tel: (352)792-6707

Please fill in the following:

Legal Name: **Date of Birth:**

Email: ***(This is how the Florida Department of Health (DOH) will communicate with you):***

SS# ***(Required for registration into the MMUR-We promise to keep it safe and secure):***

Address (***Please Note: The address on your driver's license is the only location the DOH will mail your official card to):***

City/State/Zip Code/County:

Telephone Number:

Alternate Contact Name: **Alt. Tel. Number:**

Your weight: _____ (lbs) If female, are you currently pregnant? **Yes** **No**

Release of liability:

I affirm that the information on this form is correct and that any medical history presented or discussed with the doctor is factual and complete. I do not plan or intend to use my physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification and medical purposes, I authorize to converse with the physician, staff and representatives of this HIPPA compliant practice regarding my confidential medical history and qualifying medical marijuana condition. I understand that I must be a Florida State resident to obtain approval or recommendation for the use of medical marijuana under the Compassionate Medical Cannabis Act SB 8-A-Medical Use of Marijuana.

I also affirm that I am interested to learn more about medical marijuana and how it may be used to treat my qualifying medical condition.

Signature:_____ Date:_____

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Charges for Services

$225 (does not include State of Florida fee of $75).

$200 Military Veteran/Senior Citizen/Hardship discount (does not include State of Florida fee of $75).

Initial physician consultation, registration into the Medical Marijuana Use Registry (MMUR) and entry of new and complete medical marijuana prescriptions.

Please Note: Obtaining your Florida medical marijuana card requires a medically qualifying diagnosis and follow-up every 7 months. Kindly bring with you any relevant medical records that support your qualifying diagnosis.

Renewal of medical marijuana prescriptions (For an established patient): $100
Your medical marijuana prescriptions will expire in 210 days and requires by regulaion a follow-up visit for renewal of prescriptions.

Transfer of Care to Green Health and Wellness (For a new patient): $150
Physician consultation, updating of your MMUR profile and entry of new and complete medical marijuana prescriptions.

Medical Marijuana Screening: Free
Meet with a board-certified physician to determine if you qualify for a Florida medical marijuana card.

Please call our office at any time if you need additional assistance or have any questions.

You may contact us or schedule an appointment at any time during your prescription cycle. We are always available to meet with you regarding your treatment plan.

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111 SE 1ST Avenue, Suite 150 (2-A), Gainesville, FL 32603, Tel: (352)792-6707

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes 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, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Treatment: WITH YOUR PERMISSION ONLY, 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights: Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. 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.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes 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.
Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our staff at (352)792-6707

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Name (Printed):_____ **Signature:**_____

Date:_____