Date: ___________________________

Last 4 Social Sec.# _____________________

Legal Name: ____

Date of Birth: _______________________

Age: _______________________________

Street Address: ___________________________

City: _______________________________

County: ____________________________

Zip: _________________________________

Cell Phone:__________________________

Email:____

Fee Collected: $299 Cash only

Please provide a copy of a valid New Jersey Drivers License or County ID and a copy of a utility bill with a matching address

Office Use Only: Pages Verified By: ___________

Acknowledgements, Agreements, Disclosures & Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree to each item. By initialing, you understand and agree to the information disclosed. If you have questions or do not understand the information below, consult with the attending physician before initializing or signing this agreement. Please do not sign this agreement and do not use marijuana if you do not understand the information you have received.

I, ____, (Patient's Legal Name), 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: cancer and a physical condition that chronically produces seizures or severe and persistent muscle spasms. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that: Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)· Other conditions for which marijuana provides relief

Include but is not limited to: Glaucoma, ALS/Lou Gehrig's disease, Parkinson's, Multiple Sclerosis, HIV, AIDS, Crohn's Disease, PTSD, Epilepsy, and If not alleviated, may cause harm to the patient's safety or physical or mental health.

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Patient agrees by initialing the following: **Initial each line**

________ I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery, drive or engage in potentially hazardous activities, or engaging in activities that require a person to be alert or respond quickly.

________I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia psychotic symptoms and overeating.

________I understand that some patients become dependent on marijuana with a potential for addiction in some patients. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms can include:

Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

________I understand that chronic use of medical marijuana can lead to laryngitis, bronchitis and general apathy. I understand that although marijuana does not produce a specific psychosis, the possibilities exists that it may exacerbate schizophrenia in persons predisposed to that disorder. I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition. I understand there are few known interactions between marijuana and medications other than herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements or other medications. I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of Marijuana as a drug. I understand the significance of this fact.

________I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law, and is listed as a Schedule 1 controlled substance by the Federal Government. I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

________I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk. I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

Patient Signature:___________________________

Date:__________________________________

RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana.

I understand that I must be a New Jersey State resident to obtain an approval or recommendation for the use of THC cannabis or medical cannabis under the Compassionate Medical Cannabis Act of 2014.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

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. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

Patient Signature: ____

Date: ___________________________________

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Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording device be it a still image, video or audio. This is a direct violation of HIPPA regulations and patient/doctor confidentiality. I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize Certified Marijuana Doctors, or its representative to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient. There are no refunds.

HIPAA Notice of Privacy Practices Acknowledgement of Receipt ________By initialing this, I hereby acknowledge that I have read and understand the privacy practice notice.