



INITIAL PATIENT INTAKE FORM

NAME: _____

Date of Birth: ____ / ____ / ____

Gender: Male Female

Address: _____

City: _____ **: State:** _____ **Zip Code:** _____

Preferred method of contact. For internal use only.

Home Phone: _____ Morning Afternoon Evening

Cell Phone: _____ Morning Afternoon Evening

Email: _____

Primary Care Physician: _____

MMJ Authorizing Physician: _____

Registered Caregiver (if applicable): _____ **Phone Number:** _____

A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please have them register for their card.

How did you hear about us?

- | | | |
|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Website | <input type="checkbox"/> Search Engine | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> DHSS | <input type="checkbox"/> Leafly | <input type="checkbox"/> Instagram |
| <input type="checkbox"/> News Article | <input type="checkbox"/> Referred | |

My Preferred Method of Cannabis Consumption: (Please check what applies below)

- | | | |
|---|--|---|
| <input type="checkbox"/> Vaporized or Smoked | <input type="checkbox"/> Topical | |
| <input type="checkbox"/> Capsules/Liquids | <input type="checkbox"/> Patches | <input type="checkbox"/> Edibles |
| <input type="checkbox"/> Sublingual (Tinctures) | <input type="checkbox"/> Suppositories | <input type="checkbox"/> I am uncertain |

I am looking for Cannabis with: (Please check what applies below)

- | | | | |
|--|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> High THC | <input type="checkbox"/> Low THC | <input type="checkbox"/> High CBD | <input type="checkbox"/> Low CBD |
| <input type="checkbox"/> 1:1 Ratio THC / CBD | <input type="checkbox"/> I am NOT sure of my medical needs | | |

Frequency of use (if applicable): _____



NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I understand, that under the Health Insurance Portability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understand the Notice of Privacy Practices. Organic Remedies reserves the right to change the terms of its Notice of Privacy Practices. I understand Organic Remedies will provide a current Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Authorized Patient's Representative: _____

Relationship: _____

Signature: _____

----- FOR OFFICE USE ONLY -----

I was unable to obtain the patient / patient's representative's signature.

Employee's Name: _____ Date: _____

Reason: _____



Patient & Caregiver Purchase Disclosures

Please read all information below, initial beside appropriate lines and sign to acknowledge these disclosures and confirm understanding.

Organic Remedies encourages patients new to medical marijuana therapy to receive a pharmacist consult. However, if you have received a consult with a pharmacist at another location prior to visiting us or feel comfortable in your knowledge of appropriate therapies for your condition, you are not required to have a consultation with a pharmacist. Our pharmacists are available to schedule follow-up consults as needed to help you maximize therapy.

- I would like to schedule a pharmacist consult. _____
- I decline an initial pharmacist consult. _____

Patient/Caregiver understands that they are prohibited from consuming medical marijuana in **public spaces** and also will not do so within 1000 feet of the facility or in any other place prohibited by law. Medical marijuana should only be consumed in private locations not generally open to the public. _____

Under the law of the State of Missouri, I understand that I am not immune from the imposition of any civil, criminal, or other penalties for:

- Operating, navigating, or being in physical control of any motor vehicle, boat, or aircraft while under the influence of medical marijuana.
- Consumption of medical marijuana in any public place
- Consumption of medical marijuana in a motor vehicle
- Undertaking any task under the influence of medical marijuana when doing so would constitute negligence or professional malpractice. _____

It is unlawful for anyone other than the Patient/Caregiver to possess or use medical marijuana. I understand it is illegal to divert, transfer, sell, or give this or any medical marijuana products to anyone other than the Patient/Caregiver to whom it was dispensed. I agree to keep all medical marijuana away from children, other than the patient. _____

It is unlawful under Federal Law, to possess, use manufacture or distribute Marijuana. I understand obtaining medical marijuana under Missouri Regulations does not exempt me from Federal prosecution, under the laws and penalties provided by the Federal government. _____

I understand that scientific research has not established the safety of medical marijuana use by pregnant women and nursing mothers and should not be consumed during pregnancy or while breast feeding. _____



Patient & Caregiver Purchase Disclosures

It is the principle mission of the FDA Center for Drug Evaluation and Research to ensure drugs marketed in the United States are safe and effective. The center ensures that drugs work correctly and that their health benefits outweigh their known risks. Medical marijuana remains a Schedule 1 substance under the Controlled Substance Act, and as such has not received FDA approval. I understand the use of medical marijuana to treat a medical condition is not yet approved by the U.S Food and Drug administration.

Organic Remedies is committed to supporting our patients in reaching their individual treatment goals. Our pharmacists are available for telephonic or video consults during facility open hours. We encourage all Patients/Caregivers to check in regularly and disclose any concerns related to their therapy. I understand and acknowledge that open communication with my pharmacist is available to me to maximize my therapy.

Missouri regulations allow qualifying patients to purchase, or have purchased on their behalf by their primary caregivers, no more than four (4) ounces of dried, unprocessed marijuana per qualifying patient, or its equivalent, in a thirty- (30-) day period.

I confirm I have read, understand, acknowledge, and affirm the above statements. My initials beside each line and signature below document my understanding and acknowledgement of this information.

(Signature)

(Date)

(Print Name)