The Institute of Multidimensional Medicine, PLLC

MMP REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:			Home phone no.: ( )	
City:	State:	ZIP Code:			Cell phone no.: ( )	
E-mail Address:	Occupation:				Work phone no.: ( )	
Referred by:						

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TIMM, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

The Institute of Multidimensional Medicine, PLLC

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AUTHORIZATION & ACKNOWLEDGEMENTS

TREATMENT AUTHORIZATIONS: I [Print Name] _____ authorize medical treatment of myself or my minor child by physicians, dentists or medical assistants and staff at The Institute of Multidimensional Medicine (TIMM, PLLC).

NOTICE TO NATURE OF SERVICES: I understand that care I receive at TIMM, PLLC may be non-traditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may no t be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my doctor may request laboratory evaluation that may include venipuncture, and analysis of stool.

NOTIFICATION THAT SERVIES ARE NOT PRIMARY CARE: I understand that Dr. Mines is not acting as my primary care physician unless agreed to by Dr. Mines in writing. I understand that even though Dr. Mines may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is my best interest to also have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform TIMM, PLLC who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physician and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at TIMM in order to properly and safely coordinate my care.

My primary care physician is:

Name_____ Address_____

City/State/ZIP _____ Phone_____

The Institute of Multidimensional Medicine, PLLC

MMP REGISTRATION FORM

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.

A. The general authorization for Release of Medical Record that you sign authorizes your medical care provider, TIMM, PLLC, to disclose the information in your medical records to the extent needed for the following purposes:
   1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of your provider, or with other health care providers who are treating you or consulting in your care.
   2. For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
   3. For the purpose of provider's health care operations. This would include, such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.
   4. For the purpose of other health care provider's health care operations, to the extent that they have a treatment relationships with you.

B. A specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.
C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.
D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.
E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Institute of Multidimensional Medicine, PLLC

MMP REGISTRATION FORM

F. You have the following rights with respect you your medical records/information:
    1. You have the right to request restrictions on the use and disclosure of your medical records/information, however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
    2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
    3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
    4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
    5. You have a right to receive an accounting (list) of disclosures that are made to you or with your specific authorization, that fall within the scope of Provider's health care operations, or disclosures made for payment or treatment purposes.
    6. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, the patients may complain to Provider. Please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person.

J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an update "Notice to Patients" to all of Provider's patients.

Please acknowledge receipt and review of this notice by signing below.

_____ _____

Name of Patient (Printed) Date

_____

Signature of Patient or Lawfully Authorized Representative

The Institute of Multidimensional Medicine, PLLC

MMP REGISTRATION FORM

Please indicate which qualifying medical condition/ treatment you are seeking a recommendation for:

- ☐ Human Immunodeficiency Virus (HIV)
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Glaucoma
- ☐ Conditions characterized by severe and persistent muscle spasms, such as multiple sclerosis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Azidothymidine or Protease inhibitors
- ☐ Radiotherapy

Have you been arrested or charged with a crime in the past two years? Yes / No
(**If yes**, please describe)

_____

Are you currently attending or have you attended any substance abuse or rehabilitation program? Yes / No
(**If yes,** please provide details)

_____

Are you currently on parole or probation? Yes / No (**if yes, please see clinic manager)**

Have you been evaluated for medical marijuana use by another physician in the past? Yes / No
(**If yes,** please give name of practice, doctor, date seen and condition for evaluation)

_____

The Institute of Multidimensional Medicine, PLLC

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Have you been denied a recommendation for medical marijuana use by another MD in the past? Yes / No
(**If yes,** please explain)

_____

Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No

Did you bring any medical records with you today? Yes / No (**if yes)** what did you bring?

_____

What prescription drugs do you take currently and what dosages?

_____

Do you currently use tobacco? Yes / No (**if yes)** How often?

_____

Do you currently use marijuana? Yes / No (**if yes)** How often and what methods?

_____

Do you currently drink alcohol? Yes / No (**if yes)** How often?

_____

Do you currently use cocaine, methamphetamine, opiates, heroin or other street drugs? Yes / No

Are you allergic to any medicine? Yes / No (**if yes, list medicine**)

_____

Have you ever been hospitalized? Yes / No (**if yes, please provide dates and details**)

_____

The Institute of Multidimensional Medicine, PLLC

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Have you ever had surgery? Yes / No (**if yes, please provide dates and details**)

_____

Please circle any of the following problems anyone in your immediate family has:

Asthma / Stroke / High Blood Pressure / Cancer / Diabetes / Alcoholism / Hepatitis Tuberculosis / Substance Abuse / Kidney Disease / Heart Disease / Sinusitis /

Other

_____

Please circle any of the following problems you have:

Sleeplessness / Chest Pain / Constipation / Nausea / Diarrhea / Loss of Appetite / Stomach Pain/ Depression / Vomiting / Anxiety / Rectal Pain / Swollen Ankles / Skin Rash / Palpitations / Headaches/ Chronic Pain / Muscle Spasm / Difficult Swallowing / Coughing / Fever / Heart Burn / Seizures / Eye Problems / Blood in Bowels /

Other

_____

Are there any other health problems that occur frequently with you or your family? Yes / No

_____

(**If female**) Are you currently pregnant? Yes / No
(**If female**) Are you planning on getting pregnant? Yes / No
(**If female**) Are you currently breast feeding? Yes / No

The Institute of Multidimensional Medicine, PLLC

MMP REGISTRATION FORM

Acknowledgements, Agreements, Disclosures and 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 Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions & Treatments.

Qualifying medical conditions:

- Human Immunodeficiency Virus (HIV)
- Acquired Immune Deficiency Syndrome (AIDS)
- Glaucoma
- Conditions Characterized by severe and persistent muscle spasms, such as multiple sclerosis
- Cancer

Qualifying medical treatments

- Chemotherapy
- Use of azidothymidine or protease inhibitors
- Radiotherapy

Patient agrees by initialing the following:
Please Initial

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. _____

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. _____

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I understand that some patients become dependent on marijuana. 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 is 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. _____

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. _____

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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 should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report any such problems or effects to the attending physician. 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 in the lungs, mouth and tongue. I have been advised that medical marijuana smoke contain chemicals known as tars that may be harmful to my health. I understand that there are many methods of intake that substantially reduce the harmful effects of smoking such as vaporizers, edibles, drops, etc. _____

I understand Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, disturbances to heart rhythms, numbness in the limbs, anxiety attacks and incapacitation. _____

If I start taking medical marijuana, I agree to tell my attending physician if I: Start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking. _____

I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding. _____

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana. I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence. _____

Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants. _____

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I am not permitted to smoke within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home. _____

I agree to follow up with the attending physician at The Institute of Multidimensional Medicine PLLC with supporting medical records pertaining to my medical conditions. _____

I understand the attending physician; staff and or representatives of The Institute of Multidimensional Medicine PLLC are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives of The Institute of Multidimensional Medicine PLLC will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana. _____

I certify that I have read this document and declare under penalty of perjury that the information contained herein is true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, The Institute of Multidimensional Medicine PLLC will report any of the above mentioned activities to the appropriate local authorities. _____

The physician, staff and representatives of The Institute of Multidimensional Medicine PLLC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use. _____

The undersigned applicant assumes any and all risk or liability that may result under District of Columbia and federal laws and regulations. _____

The undersigned applicant acknowledges that he/she understands that the medical marijuana laws and enforcement thereof of the District of Columbia and the Federal government are subject to change at any time and that The Institute of Multidimensional Medicine PLLC shall not be liable as a result of these changes; _____

The Institute of Multidimensional Medicine, PLLC

MMP REGISTRATION FORM

The undersigned specifically acknowledges receipt and advisement of the notices below. The undersigned agrees to and accepts the limitation of liability against The Institute of Multidimensional Medicine PLLC, and the requirement to indemnify, hold harmless, and defend The Institute of Multidimensional Medicine PLLC. _____

a. Limitation of Liability

The Institute of Multidimensional Medicine PLLC shall not be liable for any damage, injury, accident, loss, compensation or claim, based on, arising out of or resulting from patient's participation in the District of Columbia's medical marijuana program, including but not limited to the following: arrest and seizure of persons and/or property, prosecution pursuant to federal laws by federal prosecutors. This Limitation of Liability provision shall survive expiration or the earlier termination of this registration if such registration is granted. _____

b. Indemnification, Hold Harmless and Defense Obligations

The Patient hereby indemnifies and holds The Institute of Multidimensional Medicine PLLC, its officers, directors, employees, affiliates and agents ("Indemnified Parties") harmless and shall defend the Indemnified Parties (with counsel satisfactory to The Institute of Multidimensional Medicine PLLC) from and against any and all losses, costs, damages, liabilities, expenses, claims and judgments (including, without limitation, attorneys fees and court costs). _____

c. Federal Prosecution

The United States Congress has determined that marijuana is a controlled substance and has placed marijuana in Schedule I of the Controlled Substance Act. Growing, distributing, and possessing marijuana in any capacity, other than as a part of a federally authorized research program, is a violation of federal laws. The District of Columbia's law authorizing the District's medical marijuana program will not excuse any registrant from any violation of the federal laws governing marijuana or authorize any registrant to violate federal laws. _____

The undersigned applicant certifies that the application is complete and accurate. _____

Patient Signature _____ Date _____