Jamal Aljari, M.D.
Valley View Health Services
ADDICTION TREATMENT CENTER
ADDICTION MEDICINE TREATMENTS •
NON-OPIOID PAIN MANAGEMENT •
MEDICAL MARIJUANA CERTIFICATION •
INTERNAL MEDICINE CONSULTS •
1001 9th Ave., Suite 2,
Brackenridge, PA 15014
724-393-1756

PATIENT IN-TAKE FORM

Please enter your information Pennsylvania Patient ID: _____

First Name Last Name

_____ _____

Date of Birth (mm/dd/yyyy) Gender (please choose one)

_____ Female Male No Answer

Street Address Apt/Unit #

_____ _____

City PA Zip Code

_____ _____ _____

Contact Phone (_____) _____

Email _____

Emergency Contact Name _____

Emergency Contact Phone (_____) _____

Medical Information

Do you (patient) or have you had any of the following? Choose all that apply.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Muscle Cramps
- ☐ Syncope
- ☐ Heart Disease Arthritis
- ☐ Arthritis
- ☐ Abdominal Problems
- ☐ Lung Disease
- ☐ Seizures
- ☐ Headaches

Please check off the medical condition(s) that you would like to review today:

- ☐ Amyotrophic Lateral Sclerosis — How Long? _____
- ☐ Autism — How Long? _____
- ☐ Cancer — How Long? _____
- ☐ Crohn's Disease — How Long? _____
- ☐ Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity — How Long? _____
- ☐ Epilepsy — How Long? _____
- ☐ Glaucoma — How Long? _____
- ☐ HIV/AIDS — How Long? _____
- ☐ Huntington's Disease — How Long? _____
- ☐ Inflammatory Bowel Disease — How Long? _____
- ☐ Intractable Seizures — How Long? _____
- ☐ Multiple Sclerosis — How Long? _____
- ☐ Neuropathies — How Long? _____
- ☐ Parkinson's Disease — How Long? _____
- ☐ Post-traumatic Stress Disorder — How Long? _____
- ☐ Sickle Cell Anemia — How Long? _____
- ☐ Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective — How Long? _____

Insurance Authorization and Assignment

Medical Certification PC and staff are dedicated to providing the best possible care and services, which may include diagnostic tests. We have adopted the following policies in order to minimize confusion or misunderstanding between our patients and practice.

Please provide a copy of your insurance card to attach to your file or allow us to photocopy your insurance card. Some Diagnostic tests that will be done at your visit may be covered by your medical insurance carrier. If they are not covered by your Medical insurance, you will not receive a bill from the Laboratory doing the testing or from PA Green Medical or Medical Certification PC. You may receive a EOB statement, but that is not a bill and no remittance is required on your part.

I hereby authorize Medical Certification PC to furnish all necessary information to my insurance carrier concerning any of my or my dependent's illness and treatment. I hereby authorize Medical Certification PC to release my insurance information to a third party billing for services related to my treatment process. I hereby assign to the third party billing or supplier all payments for medical services rendered to me or my dependents. I have read and fully understand the policies of this office regarding payments and insurance.

Patient Signature _____ **Date**_____

For MEDICARE patients: I hereby authorize Medical Certification PC to furnish all necessary information to my insurance carriers concerning any of my or my dependent's illness and treatment. I hereby authorize Medical Certification PC to bill my insurance for services related to my treatment process. I hereby assign to third party billing or supplier all payments for medical services rendered to me or my dependents. I have read and fully understand the policies of this office regarding payments and insurance.

Patient Signature _____ **Date** _____

Notice of Privacy Practices Patient Acknowledgement
Authorization for Use/Disclosure of Protected Health Information (PHI)

I have received the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my PHI that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize Medical Certification PC and staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individuals:

List any person(s) and their contact information that you are allowing this office to communicate with regarding your PHI:_____

Patient Manner of Contact
In general, the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

***I Wish To Be Contacted in The Following Manner:
_____NO RESTRICTION (Okay to contact using phone, e-mail or home address)
_____Phone ONLY message
_____Home Address ONLY message
_____E-mail ONLY message
_____Other:_____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Patient Signature _____**Date** _____

Relationship to Patient, if signed by a personal representative i.e. parent, legal guardian, etc. _____

Authorization for Release of Confidential Records

I, **(Print Patient Name)**_____, **date of birth** _____ hereby authorize Medical Certification PC to disclose and verify me as a patient to any law enforcement agency, my physician(s), Child Protective Services or any Pennsylvania State approved dispensary. This is valid during the period of time for which the recommendation has been issued. This consent is subject to written revocation only, at any time except to the extent that action has already been taken on the basis of this consent.

I give Medical Certification PC and the attending physician permission to validate my status as a patient using the online patient verification system.

I give permission for my medical records, file and insurance information to be reviewed by another physician or laboratory working with Medical Certification PC. I understand that this might happen if the original doctor that evaluated me required a secondary opinion, is not available, off premise, has moved or terminated his/her practice.

Patient Signature _____**Date**_____

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 HIPAA 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 Medical Certification PC or it's representative, to discuss my medical condition.

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 or 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.

Patient Name(Print)_____

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 authorize Medical Certification PC to converse, electronically submit, and release information of my medical condition.

I understand that I must be a Pennsylvania resident to obtain an approval or recommendation for the use of medical cannabis. 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. I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

Pennsylvania's Medical Marijuana Act – Senate Bill 3, approved April 12, 2016 – provides for the possession of medical marijuana for the personal medical purposed of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medical use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.
Furthermore, the undersigned, or anyone acting on my behalf, holds PA Green Medical, Medical Certification PC, the physician and his/her principals, agents and employees, free of and harmless from any liability resulting from my release, a data breach and my use of medical marijuana. I further understand that by signing below, I am authorizing the release of any part of this record.

Patient Name (Print)_____

Patient Signature _____ **Date**_____

Acknowledgements, Agreements, Disclosures and Informed Consent

I, _____, **(Print Patient's Name),** understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions.

I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition and 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 may 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 bodies immune system, increased talkativeness, impairment of motor skills, delayed reaction time, lack of physical coordination, paranoia, and increase eating.

I understand that some patients may become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms may include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

I understand the chronic use of medical marijuana may lead to laryngitis, bronchitis and general apathy. I understand that although marijuana does not produce a specific psychoses, it may exacerbate schizophrenia and persons predispose 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 taking 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 a 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 illegal 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 to 4 months. If I think I may be developing a tolerance for marijuana, I will notify the attending physician. 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 it's 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 intake that substantially reduce the harmful effects of smoking such as vaporizers, and oils etc.

I understand marijuana varies in potency. The effects of marijuana may also very with the delivery method. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, heart rhythm disturbances, 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 my 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 into a baby during breast-feeding.

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 understand that 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 that US FDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

I am not permitted to smoke within 1000 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 agreed to follow up with the attending physician at PA Green Medical/Medical Certification PC with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of PA Green Medical/Medical Certification PC are neither providing, dispensing nor encouraging me to obtain medical marijuana.
I certify that I've been 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 the letter of recommendation and of any legal right to my use of medical marijuana. Furthermore, the above-mentioned activities will be reported to the appropriate local authorities.
The physician, staff and representatives of PA Green Medical/Medical Certification PC 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 my behalf, hold PA Green Medical, Medical Certification PC, the physician, 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.

Patient Signature _____ **Date**_____