Valley View Health Services Inc
Addiction Treatment Center
Internal Medicine
1001 9th Ave, Suite 2
Brackenridge, PA. 15014-1107
(724) 393-1756

Patient Registration

Today's day:_____

Last name:_____ First name:_____MI:_____

Sex: M / F (circle one)

Street Address:_____

City: _____ State:_____ Zip:_____

Email: _____Date of Birth: _____

Cell Phone:_____ Home Phone:_____

Work Phone:_____ SS#: _____

Preferred Contact For Appointment Reminders: text to cell/ call to home (check one)

Primary Insurance Information:

Insurance Company Name: _____

Name of Insured:_____

Address:_____

City, State, Zip: _____

SS# of Insured: _____ ID #: _____

Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____

Name of Insured:_____

Address:_____

City, State, Zip: _____

SS# of Insured: _____ ID #: _____

Group #: _____

Emergency Contact Information:

Contact Name: _____Cell Phone: _____

Home Phone::_____Relationship to Patient:_____

Comment: _____

Sibling Information:

Name:_____ Date of Birth: _____

Sex: M / F (circle one)

Name:_____ Date of Birth: _____

Sex: M / F (circle one)

Name:_____ Date of Birth: _____

Sex: M / F (circle one)

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, fees for in-office services and/or tests, and any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system, or text message, regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____

Signature of Patient/Legal Representative

_____

Date

_____

Patient/Legal Representative completing this form (Please Print)

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PATIENT QUESTIONNAIRE & EXAM	DATE:
NAME:	DOB:
ADDRESS:	OCCUPATION:

HOSPITALIZATIONS

If you have been in hospital overnight - state year - illness/operation
(Do not include normal pregnancies. Please start with most recent.)

YEAR	ILLNESS / OPERATION	YEAR	ILLNESS / OPERATION

PAST MEDICAL & FAMILY HISTORY

Please check if you (self) or any blood relative had any of the following conditions:

	SELF	RELATION	EXPLAIN		SELF	REL.	EXPLAIN
1) RECENT WEIGHT LOSS		//////////		19) NEUROLOGICAL			
2) MIGRAINE HEADACHES				20) ARTHRITIS			
3) EPILEPSY I CONVULSIONS				21) OSTEOPOROSIS			
4) EYE DISEASE (OTHER1HAN6IASSES)				22) CANCER - TYPE:			
5) HEARING DISORDER				23) BLEEDING DISORDER			
6) RECURRENT - NOSE BLEEDS		//////////		24) BLOOD TRANSF.		//////////	
7) SINUS / THROAT INFECT(S)		//////////		25) ANEMIA			
8) ANGINA - CHEST PAIN				26) DIABETES			
9) HEART ATTACK				27) THYROID DISEASE			
10) HIGH BLOOD PRESSURE				28) ALCOHOL OR DRUG ABUSE			
11) STROKE				29) MENTAL ILLNESS			
12) HIGH CHOLESTEROL				30) DEPRESSION			
13) HEART VALVE DISORDER				31) PSORIASIS I ECZEMA			
14) LUNG DISEASE				32) HAIR LOSS			
15) STOMACH ULCER				33) ACCIDENT - MAJOR		//////////	
16) BOWEL PROBLEMS				34) STD/HERPES/HIV			
17) LIVER DISEASE I HEPATITIS				35) ANXIETY			
18) KIDNEY I BLADDERPR I OB				36) BACK PAIN			
				37) NECK PAIN			

LIST ALL MEDICATIONS YOU TAKE:

MEDICATIONS	DOSE	Time/day

DO YOU NOW OR HAVE EVER CONSUMED:

CIGARETTES Y N PKG/DAY _____ #YRS_____
ALCOHOL Y N DRINKS/WK _____
COFFEE/TEA Y N CUPS/DAY _____
STREET DRUGS Y N

TYPE: _____

THE LAST TIME YOU HAD A - (YEAR):

FLU VACCINE ____ TETANUS SHOT ____
HEPATITIS VACCINE ____ PNEUM. SHOT ____
T.B. TEST ____ RECTAL EXAM ____
STOOL BLOOD TEST ____ EYE EXAM ____
CHOLESTEROL TEST ____ PROSTATE EXAM ____
(result) _____ COLONOSCOPY ____

DRUG ALLERGIES

DRUG	*REACTION*

FOR WOMEN ONLY

DATE OF LAST MENST. PERIOD _____

ARE YOU USING BIRTH CONTROL? Y N
TYPE: _____
OF PREGNANCIES: _____
OF BIRTHS: _____

YR. OF LAST:
___ PAP TEST ☐ NORMAL ☐ ABNORMAL
___ BREAST EXAM ☐ NORMAL ☐ ABNORMAL
___ MAMMO. ☐ NORMAL ☐ ABNORMAL

PAST SURGICAL HISTORY: *Please list all previous surgeries and the years:*

Do you have any other problems for which you have been seeing a doctor on a regular basis? - Please list them:

REVIEW OF SYMPTOMS ☑ **Please check for current problems.**

MAIN PROBLEMS 1) _____ 2) _____ 3) _____

☐ Decreased Hearing	☐ Leg pain - when walking	☐ Urine infections - frequent	*Do you have a living will?* ☐ Yes ☐ No
☐ Hot/Cold intolerance	☐ Varicose veins / Phlebitis	☐ Sexually transmitted diseases	
☐ Ringing in ear(s)	☐ Cold numb feet	☐ Weight-loss	
☐ Increased thirst	☐ Loss of appetite - recent	☐ Gain - recent	*Durable Power of Attorney?* ☐ Yes ☐ No
☐ Ear infections - frequent	☐ Difficulty swallowing	☐ Anemia	
☐ Dizzy spells	☐ Heartburn	☐ Bruise easily	
☐ Fainting spells	☐ Persistent nausea / Vomiting	☐ Blood transfusions	*Do you use seat belts?* ☐ Yes ☐ No
☐ Eye pain	☐ Abdominal pain - chronic	☐ Chronic fatigue	
☐ Dbl./Blurred Vision	☐ Gall bladder trouble	☐ Seizures	
☐ Nose bleeds - recurring	☐ Jaundice / Hepatitis	☐ Tremor/hands shaking	*Do you keep a gun in the home?* ☐ Yes ☐ No
☐ Sinus trouble	☐ Diarrhea	☐ Numbness/tingling sensation	
☐ Sore throats - frequent	☐ Constipation	☐ Muscle / Joint pain	*Is it loaded?* ☐ Yes ☐ No
☐ Hoarseness - prolonged	☐ Diverticulosis	☐ Headaches - frequent	
☐ Hayfever/Allergies	☐ Change in Bowel Habits	☐ Muscle weakness	
☐ Pneumonia/Pleurisy	☐ Bloody stools	☐ Back pain - recurrent	*Out of reach of Children?* ☐ Yes ☐ No
☐ Bronchitis/Chronic Cough	☐ Hemorrhoids	☐ Bone fracture / joint injury	
☐ Wheezing	☐ Urination - Overactive Bladder	☐ Foot pain ☐ Nervousness	
☐ Shortness of breath:	☐ Overnight > than twice	☐ Rashes ☐ Memory loss	*Have you ever engaged in activities that would put you at risk for aids?* ☐ Yes ☐ No
☐ on exertion	☐ More than 8x / 24 hours	☐ Hives ☐ Suicidal Thoughts	
☐ lying flat	☐ Urgency to urinate 0 w/leakage	☐ Hot flashes ☐ Mental Illness	
☐ Chest pain	☐ Decrease in force/flow	☐ Sleeping of concentration difficulty	
☐ High blood pressure	☐ Kidney stones	☐ Depression	*Have you ever worked with hazardous chemicals?* ☐ Yes ☐ No
☐ Heart murmur	☐ Stress incontinence-urine leakage	☐ Agitation	*Type?* _____
☐ Swollen ankles	with exercise / movement	☐ Moodiness	
☐ Irregular pulse	☐ Vaginal discharge | bleeding	☐ Phobias	
☐ Palpitations	☐ Blood in urine	☐ Feeling of worthlessness	*Have you ever been involved in an abusive relationship?* ☐ Yes ☐ No

ARE YOU HAVING ANY SYMPTOMS THAT YOU WOULD LIKE TO DISCUSS? ***PLEASE LIST THEM:***

FAMILY MEMBERS	**ALIVE/AGE**	**DECEASED**	**ILLNESS**
FATHER			
MOTHER			
SPOUSE			
CHILDREN 1)		*2)*	
3)		*4)*	
SIBLINGS 1)		*2)*	
3)		*4)*	

P GRANDFATHER
P GRANDMOTHER
M GRANDFATHER
M GRANDMOTHER
NOTES:

X Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

X I, _____, have received a copy of this office's Notice of
Please Print Name

Privacy Practices.

X _____ _____
Signature *Date*

(For minors, according to HIPAA law, biological parents, adoptive parents, and legal guardians may be granted access to protected health information)

My protected health information may be shared with:

☐ Spouse _____ ☐ Child _____

☐ Parent _____ ☐ Other _____

My protected health information **may not** be shared with:

☐ Spouse _____ ☐ Child _____

☐ Parent _____ ☐ Other _____

Do you have any other requests or limitations regarding your protected health information?

☐ Yes ☐ No

Comments: _____

_____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining of the acknowledgement

☐ Other (please specify) _____

_____

Signature: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A. PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ SSN: _____

SECTION B. TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

• **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

• **Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time contacting

Print Name

X I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X _____ _____

Signature *Date*

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Right to Revoke: You will have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Print Name

X I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X _____ _____
Signature *Date*

☐ If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

☐ I give permission for disclosure of my protected health information for treatment, payment activities, and healthcare operations to:

Name of Person: _____ Relationship: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

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Disclosure of Private Health Information (PHI) Access Form (Other Than TPO)

Signature of Individual Accessing PHI	Date of Access	Reason for Access

Valley View Health Services Inc
Addiction Treatment Center/Internal Medicine
1001 9th Ave, Suite 2
Brackenridge, PA. 15014-1107
Tel (724) 393-1756
Fax (724) 604-7002

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Client:_____

I hereby request and authorize:

Valley View Health Services Inc. 1001 9th Ave, Ste 2. Brackenridge, PA. 15014-1107.

Tel: 724-393-1756. Fax: 724-604-7002

To release my records from:

_____

_____

_____

The following types of information from my records (and any specific portion hereof):

❑ Medical history/Physicals

❑ Alcohol and drug abuse treatment record

❑ Laboratory and x-ray reports

❑ Psychological evaluations

❑ Other_____

For the purpose of:_____

All information I hereby authorize to release to the agency will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that this authorization will remain in effect for:
❑ Ninety (90) days unless otherwise an earlier time period of:_____
❑ One (1) year
❑ The period necessary to complete all transactions on account related to services provided to me I understand that unless otherwise limited by state or Federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Signature of Client: _____

Date:_____

Signature of Witness:_____

Date:_____

Signature of Director:_____

Date:_____

****

Clients can revoke their consents verbally or in writing to facility staff.

To be used only if the patient withdraws consent:

Signature of Client:_____

Date:_____

The information which is being disclosed is from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibit disclosures without the specific consent of the person to whom it contains. A general authorization is NOT sufficient for such release. The Federal rules restrict any use of this information from a criminal investigation or to prosecute any alcohol or drug abuse patients.

Prohibition on re-disclosure:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65. crime.

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Tel (724) 393-1756 Fax (724) 604-7002

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME: _____ **BIRTHDATE:** _____

ADDRESS: _____ **SSN:** _____

_____

ENTITY TO RECEIVE INFORMATION

Valley View Health Services Inc

Addiction Treatment Center

Internal Medicine

1001 9th Ave, Suite 2

Brackenridge, PA. 15014-1107

Tel (724) 393-1756

Fax (724) 604-7002

ENTITY TO RELEASE INFORMATION

I authorize an appropriate representative of the below entity(ies) to release information from my medical records to the above stated entity. I understand that treatment, payment, enrollment, and/or eligibility for benefits may NOT be conditioned on my signing this form.

NAME: _____ **TEL:** _____

ADDRESS: _____ **FAX:** _____

_____

INFORMATION TO BE DISCLOSED

For dates of treatment from _____ to _____

- ☐ **Complete First Party Benefits File (Consultations, Emergency Department Records, Labs, Radiology, Discharge Summary, Clinical/Progress Notes & Charts, Operative Reports, Physicians Orders, Business Records, Narratives, Billing Information and History).**
- ☐ Pertinent Parts (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's, OR Reports, Discharge Summary, ER Report).
- ☐ Discharge Summary ☐ Mental Health Records ☐ Medication Records
- ☐ Clinic/Progress Notes & Charts ☐ Emergency Dept. Records
- ☐ Other _____
- ☐ Consultation
- ☐ Lab Results
- ☐ Operative Reports ☐ Radiology (X-rays, MRIs, CT scans)
- ☐ Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment.

* *I understand that the release of my health record(s) will be only for the purpose stated on this form and only those items indicated shall be released. I understand that once copies of these records are released the copies may be further disseminated and the above named entity releasing the record is not responsible for the protection of the copies of the records.*

REASON FOR THE RELEASE

_____

REVOCATIONS

I understand that I may revoke this Authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is not effective to the extent that action has been taken in reliance of this Authorization. I understand that this Authorization is valid until the litigation of my case is completed. I agree that a photostatic copy of this Authorization shall be considered as effective and valid as the original.

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN. Patient

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign Authorization because: _____

Signature: _____ **Date:** _____

(Parent/legal or personal representative)

Witness: _____ **Date:** _____

The fax that you have received contains highly confidential and federally protected health information. Any disclosure, dissemination, distribution or copying of this information is strictly prohibited and will be prosecuted under HIPPA (Health Insurance Portability and Accountability Act of 1996) and HITECH guidelines. If you feel you have received this information in error, please contact the sender immediately by the telephone number listed above to arrange the return or destruction of the information and all copies. Thank you.

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.
The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 05/01/05, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of our Notice, please contact us using the information at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, healthcare operations, and certain other activities. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations, Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone, for any purpose. If you give us an authorization, you make revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for you healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful/intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You must make a request in writing to access your health records. You may obtain a request form by contacting the person listed below. A fee may be charged for the above listed services to cover expenses of the copies, staff time and postage if you want copies mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled/under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means; or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact:

Valley View Health Services Inc

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Medical Cannabinoids - Informed Consent & Agreement

Cannabis (i.e. marijuana) is a plant. The buds (or flowers) of this plant contain over 100 substances called cannabinoids. it is believed that when people use cannabis, it is cannabinoids that cause its effects. You have been prescribed either an extracted or synthetic cannabinoid (such as nabilone or nabiximols, available by prescription), or have been medically authorized to use cannabis itself (often via an oral oil, or sometimes inhaled).

There are both potential benefits and potential harms to using a cannabinoid as a treatment strategy. The purpose of this document is to outline various considerations so that together with your health care practitioner you can determine if they are the right therapy for you to try.

Cannabinoids should always be viewed as a trial. If the goals of using the medication are not realized, the drug will be stopped. Not all people starting cannabinoids will report a benefit from using it. Almost all people starting a cannabinoid will get at least one side effect.

The risks include:

1. Psychiatric Disturbance

This has been reported to occur in as many as 1 in 4 people who inhale cannabis (1 in 6 across cannabinoids). This includes conditions such as depression, anxiety, and psychosis.

In some people, taking cannabis may unmask schizophrenia.

Prescription cannabinoids have been shown to cause euphoria, numbness, speech disorders, and muscle disorders.

[NOTE: psychiatric disturbance may vary with varying dose, potency, product and formulation]

2. Drowsiness, Clouded Thinking, Disturbance in Attention

_____ (INITIALS)

I am aware that drowsiness or clouded thinking may make it dangerous for me to drive or operate heavy machinery. Alcohol or other medications that also cause drowsiness may worsen this effect. I agree to wait 4 hours after smoking cannabis, 6 hours after taking a cannabinoid orally, or 8 hours after feeling "high" before driving or operating heavy machinery or signing legal documents.

_____ (INITIALS)

I understand that using alcohol & a cannabinoid together is potentially dangerous. I have been advised not do this.

3. Other Side Effects include nausea, uncontrollable vomiting, headache, high blood pressure, dizziness, numbness, problems with speech, and appetite changes.

4. Cannabis Use Disorder (Addiction) is a disease that occurs in some individuals (it has been reported in about 1 in 11 individuals using cannabis recreationally). Just as becoming overweight does not necessarily mean you will develop diabetes, taking a cannabinoid does not necessarily cause addiction. However, if you have risk factors for addiction (such as a strong family history of drug or alcohol abuse) or have had problems with drugs or alcohol in the past you must notify me since we do not want to cause a relapse. The extent of this risk is not certain. Even people who take a cannabinoid as recommended can become addicted to it.

_____ (INITIALS)

I have notified Dr_____ of any personal or family history of drug or alcohol abuse.

There are numerous laws and regulations regarding cannabinoids that your practitioner has to adhere to. The following requests are considered standard best practice and help this healthcare practice and you comply with these laws and regulations.

The patient agrees:

- To reliably attend appointments with the practitioner.
- To not use any illegal substances, such as cocaine or heroin.
- To not use unregulated cannabis/marijuana – only to use the supply authorized by the practitioner.
- To not seek out cannabis/marijuana, or any other controlled substance, from any other provider.
- To not give or sell the prescribed/authorized cannabinoid to anyone else, including family members.
- To use cannabinoids as prescribed/authorized and not in larger amounts or more frequently.
- To other pain consultations/management strategies, including non-drug approaches, as advised.
- To safely store the medication. (This is REALLY important as kids can easily accidentally ingest these substances.)
- To not take medical cannabis outside of Canada.
- To periodic urine drug tests as requested by the practitioner or clinic.
- To view cannabinoids as a trial, which will be discontinued if benefits of therapy are not seen, or harms outweigh benefits.
- To understand that if any of these conditions are broken, or if harms begin to outweigh benefits, the practitioner may refuse to provide future medical authorization for a cannabinoid.
- To report any side effects from using cannabinoids to my practitioner as soon as possible.

The practitioner agrees:

- To be able to see you within a reasonable time for follow up
- To discuss the results of urine drug testing with you before making any decisions
- If using to treat pain, to offer you treatment for your pain with therapies besides a cannabinoid if these medications are creating more harm than benefit.

Signatures:

_____ _____

Practitioner signature Date

X _____ _____

Patient signature Date

X _____

Patient name (print)

Form available at:
-Word (Modifiable): http://www.rxfiles.ca/rxfiles/uploads/documents/Cannabinoids-Informed-Consent-And-Agreement.docx
-Pdf: http://www.rxfiles.ca/rxfiles/uploads/documents/Cannabinoids-Informed-Consent-And-Agreement.pdf

Valley View Health Services Inc
Addiction Treatment Center
Internal Medicine
1001 9th Ave, Suite 2
Brackenridge, PA. 15014-1107
(724) 393-1756

$15.00 FEE WILL BE CHARGED
FOR THE COMPLETION OF ANY FORMS.

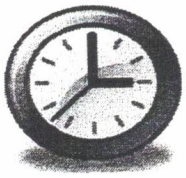
$20.00 FEE WILL BE CHARGED
FOR COPY OF MEDICAL RECORDS REQUESTED BY PATIENT.

FINANCE CHARGES/LATE FEE WILL BE ADDED TO ALL ACCOUNTS
30 DAYS DELINQUENT.

$35.00 FEE WILL BE CHARGED
IF 24 HOURS CANCELLATION NOTICE IS NOT GIVEN.

$10.00 FEE WILL BE CHARGED
IF CO-PAY IS NOT PAID AT TIME OF SERVICE.

Thank you for your cooperation.



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Business Hours

	Open	Close
Monday	9:00AM **to** 5:00PM	
Tuesday	9:00AM **to** 5:00PM	
Wednesday	9:00AM **to** 5:00PM	
Thursday	9:00AM **to** 5:00PM	
Friday	9:00AM **to** 5:00PM	
Saturday	- **CLOSED**	
Sunday	- **CLOSED**	

Have a great day!