Medical Marijuana Program in New Jersey

Our Commitment to You

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.
- If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that your keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- We are sorry, but due to the high fax volume we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    1. Photo ID
    2. MRI films and reports, CT scan films and reports, bone scan reports
    3. EMG reports
    4. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
    5. List of current medications

Financial Policy

- We are committed to providing you with the best possible care.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.
- Returned cheeks will be subject to **an additional $25 service fee**.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.

Medical Marijuana Program in New Jersey

I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for this account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

___________________________________ X ___________________________ __________

Patient Name Signature Date

Medical Marijuana Program in New Jersey Disclaimer

I wish to participate in Medical Marijuana Program in New Jersey at Relievus. I understand and acknowledge that Medical Marijuana Program in New Jersey is **NOT** be covered by either federal or private payors and my personal healthcare insurance does **NOT** cover Medical Marijuana Program in NJ. Thus, I agree not to make a claim for Medical Marijuana Program in NJ with my personal healthcare insurance carrier and further agree and acknowledge that I must pay by cash or major credit card all related healthcare costs related to the Medical Marijuana Program in Pennsylvania at Relievus.

By signing below, I accept and acknowledge that **I am opting out** of using my healthcare insurance for the Medical Marijuana Program in NJ and accept paying cash or major credit card for these services.

Acknowledged and accepted by:

____

Patient Name

____

Patient Signature Date

Medical Marijuana Program in New Jersey

MEDICAL MARIJUANA ACKNOWLEDGEMENT Of DISCLOSURE AND INFORMED CONSENT

1. I, ____ 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:
   - **Amyotrophic Lateral Sclerosis (ALS)**
   - **Anxiety**
   - **Cancer**
   - **Chronic pain of visceral origin**
   - **Chronic pain related to musculoskeletal disorders**
   - **Crohn's Disease**
   - **Epilepsy**
   - **Glaucoma**
   - **HIV (Human Immunodeficiency Virus) / AIDS (Acquired Immune Deficiency Syndrome)**
   - **Inflammatory Bowel Disease**
   - **Intractable Muscle Spasticity**
   - **Intractable Seizures**
   - **Migraine**
   - **Multiple Sclerosis**
   - **Muscular Dystrophy**
   - **Opioid Use Disorder as an adjust to Medication Assisted Therapy**
   - **Post-traumatic Stress Disorder (PTSD)**
   - **Seizure Disorder**
   - **Terminal illness with prognosis of less than 12 months to live**
   - **Tourette's Syndrome**
2. I understand that medical marijuana use for treatment of these conditions has not been approved by the Federal Drug Association ("FDA")
3. I have been advised and understand that the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that could impair my ability to drive, operate heave machinery, or engage in potentially hazardous activities.
4. 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 know n carcinogens (chemicals that can cause cancer), and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth, and tongue. I have been advised that cannabis (medical marijuana) smoke contains chemicals known ' as tars that may be harmful to my health. Vaporizers may substantially reduce many of the potentially harmful smoke toxins that normally present in marijuana smoke.
5. Medical marijuana is available in many different forms and you are encouraged to speak with your provider about what he/she feels would be best for your diagnosis. Patients enrolled in our Medical Marijuana Program here at Relievus are encouraged to use edible or ingested forms of medical marijuana as inhalation of medication is

associated with lung pathology including lung cancer. Patients who are on home oxygen are also encouraged to use edible forms of medication to avoid the risk of burn injuries if medication is smoked.

6. I understand that the side effects may occur while l am taking medical marijuana. These side effects have been explained to me. Side effects of medical marijuana can include, but are not limited to:

Headache	Decreased blood flow to brain	Altered body temperature	Fatigue
Inattention	Aggressiveness	Sedation	Anxiety or panic
Inability to concentrate	Decreased verbal skills	Nystagmus	Decreased coordination
Suicidal ideation	Increased food consumption and weight gain	Rapid heart rate	Reduced muscle strength
Altered libido / Impotence	Hallucinations	Confusion	Paranoia
Euphoria	A motivational syndrome	Increased talkativeness	Hunger
Addictive behaviors	Depersonalization	Reduced testicular size	

7. 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, disturbances to heart rhythms and numbness of the limbs and/or hacking cough
8. For some patients, chronic marijuana over use can lead to laryngitis, bronchitis and general apathy.
9. Using marijuana may decrease reproduction function in men as well as women. Women who are trying to conceive, or who are pregnant or breast-feeding should not use marijuana. Marijuana may increase risk of leukemia in children whose mothers smoked marijuana during pregnancy. Marijuana may also increase risk of an aggressive form of testicular cancer in men.
10. I understand that some patients can become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms, while generally mild, can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbances, unusual tiredness, troubled concentration and/or loss of appetite.
11. Although marijuana does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in persons predisposed to that disorder.
12. I understand that using marijuana while under influence of alcohol is not recommended.
13. 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.
14. I agree to tell the attending physician/nurse practitioner/ physician assistant /medical provider if I have ever had symptoms of depression, been psychotic, attempted suicide, or had any other mental problem. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of these problems.
15. I understand that the attending physician/nurse practitioner/ physician assistant /medical provider does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.
16. I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis (medical marijuana) provides substantia l relief and improvement in my condition.
17. If I start taking medical marijuana, I agree to tell my attending physician/nurse practitioner/medical provider if I experience any adverse symptoms (side effects).
18. I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and may contain unknown quantities of active ingredients, impurities and I or contaminants. I n requesting an approval or recommendation for the use of this plant as medication I assume full responsibility for any and all risks of this action.

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19. I am advised that the use of cannabis may 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 I or other individuals as a result of my use of cannabis.
20. Some users develop a tolerance to marijuana. This means higher and doses are required to achieve the same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician.
21. I agree to discontinue its use and report problems or side effects to the attending physician/nurse practitioner / medical provider.
22. I understand that the attending physician /nurse practitioner/physician assistant/medical provider, staff and representatives of this practice are neither providing nor dispensing cannabis, nor are they encouraging any illegal activity in my obtaining medical marijuana.
23. I understand that the attending physician/nurse practitioner/physician assistant/medical provider in order to conduct an appropriate evaluation, must do a physical exam and take my prior medical history and family history.
24. At this time, cannabis is an alternative or complementary treatment. I understand to receive a recommendation for cannabis use, I should have tried, or be willing to consider trying, at least one other recommended treatment from a medical provider. I have obtained or attempted to obtain medical records pertaining to my condition or currently have to medical records pertaining to my condition and agree to be referred for further evaluation as the physician deems necessary.

____ X _____________________________ __________

Patient's Name Signature Date

Release of All Claims and Liability

1. I understand that should I be given a recommendation for medical use of cannabis, I understand that I must be regularly followed- up by a doctor and appear for a re-evaluation at a date specified by the attending physician/nurse practitioner / medical provider.
2. I request a consultation by an attending physician/nurse practitioner/medical provider for the sole purposes of determining the appropriateness of medical cannabis treatment. I, the undersigned, understand that there are no representations about the medical efficacy of cannabis.
3. I understand that the attending physician/nurse practitioner /medical provider , staff, and representatives at Relievus – Advanced Spine and Pain, LLC are addressing specific aspects of my medical care, and, unless otherwise stated are in no way establishing themselves as my primary care provider . The attending physician/nurse practitioner/physician assistant/medical provider is only rendering an opinion regarding the therapeutic indication of the use of medical marijuana.
4. My heirs, assigns, or anyone acting on my behalf, hold the attending physician/nurse practitioner/medical provider and his/her principles, agents and employees, free of and harmless from any responsibility and liability resulting from the use of cannabis. In case any claim or dispute arises, I agree to arbitrate such claims/disputes and I agree that Pennsylvania law will govern such claims/disputes.
5. Further, if any of these clauses is deemed invalid, the other clauses will remain in full force and effect.

____ X _____________________________ __________

Patient's Name Signature Date

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Last Name: ________________________First Name: _________________________ SEX: M F

If patient is a minor, name of parent or guardian accompanying patient:_______________________

Relationship to patient: ________________________Phone # (if different): _____________________

Address: ____

City: ___________________________________ State: _____________________ Zip Code: ________

Home Phone: ____________________________ Cell Phone: __________________________________

Email: ____

Date of Birth: ____________________________ SS#: _______________________________________

(Circle one) Married Single Divorced Widowed Other

Referred by: ___________________________ Phone: ___________________Location: ___________

Family Doctor: _________________________ Phone: ___________________Location: ___________

Emergency Contact: ____________________________________Phone: ________________________

Are we authorized to release your medical information to the listed emergency contact? Yes or No

SIGNATURE: ____ DATE: _________________

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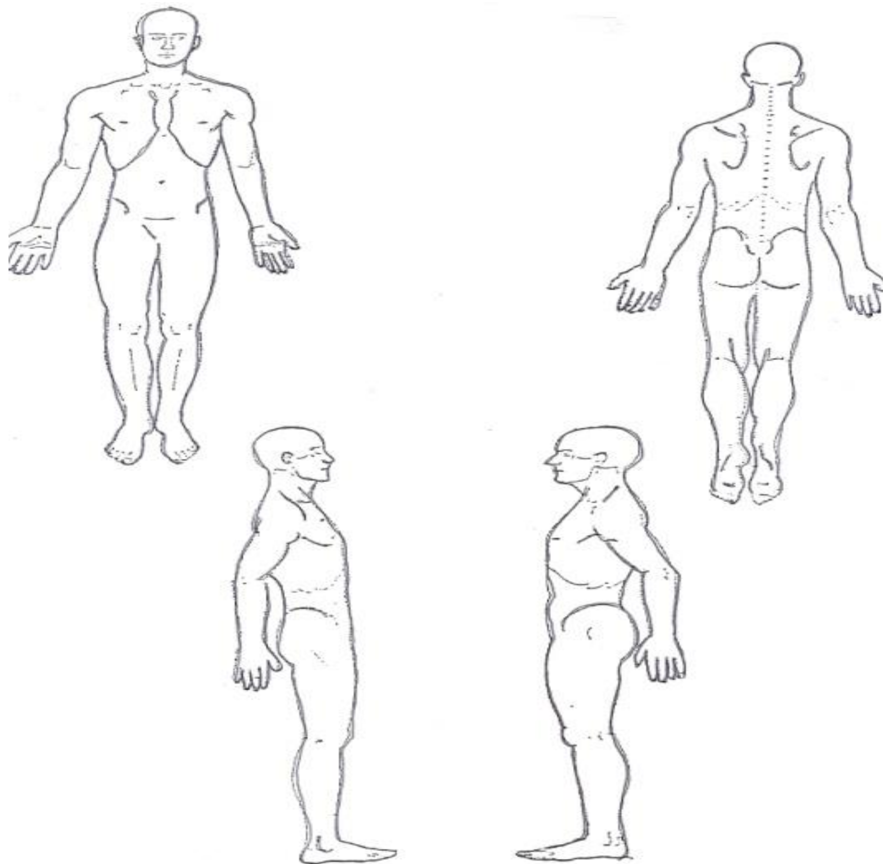
Medical marijuana is available in many different forms and you are encouraged to speak with your provider about what he/she feels would be best for your diagnosis. Patients enrolled in our Medical Marijuana Program here at Relievus are encouraged to use edible or ingested forms of medical marijuana as inhalation of medication is associated with lung pathology including lung cancer. Patients who are on home oxygen are also encouraged to use edible forms of medication to avoid the risk of burn injuries if medication is smoked. • Today's date: ______________ • Name : ____

• Age____________ • Date of Birth ______________________ • Height ___________ • Weight ____________

□ Right hand dominant □ Left hand dominant • Sex : □ Male □ Female

Referral Physician: ________________________ Primary Care Physician: _____________________

Chief Complaints;



• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

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- Average Pain Level (0 ~ 10)   0   1   2   3   4   5   6   7   8   9   10

- Location ____

____

____

- Does the pain radiate anywhere (“shooting down” or “shooting up”)

____

- When was the pain started ? ____

____

- How was the pain started ? ____

____

- Please, describe your pain

□ Dull □ Aching □ Sharp □ Shooting □ Stabbing □ Throbbing □ Numbness □ Burning

____

- How often is your pain present ? □ Occasional □ Frequent □ Constant
- Worst time of day? □ Morning □ Afternoon □ Evening □ Night □ All the time
- Any color change or temperature change? ______________________________
- Numbness in anywhere? ____
- “Pins and needles” ? ____
- Weakness? (Right leg, right arm, both legs….) ___________________________
- Swelling ? ____
- What makes symptoms worse/exacerbate? ________________________________

  □ Walking □ Standing □ Lying down □ Sitting □ Bending forward □ Bending backward □ Driving
  □ Coughing □ Bowel movement □ Cold weather □ Hot weather □ Rainy day □ Lifting objects

- What makes the symptoms better ? ____

  □ Resting □ Massage □ Exercise □ Sitting □ Lying down □ TENS unit □ Physical therapy

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☐ "Injections" ☐ Sleeping ☐ Medication (Names) ___________________ ☐ Other ___________________

- Sleeping : ☐ Well ☐ "OK" ☐ Terrible ☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ >10 hrs
- How often do you wake up at night? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >5 times

Previous Treatments

Physical therapy ☐ Location ________________________ ☐ Date of Last PT _______________ ☐ Duration _______________

Acupuncture _______________________ Psychotherapy ____________________________

Chiropractor _____________________ Other (Biofeedback, Meditation, Yoga, Swimming)

TENS Unit ☐ Never used ☐ I have a unit ☐ I don't have one ☐ Used at home daily ☐ Used at home as needed ☐ Used during PT

Review of System

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐Weakness ☐Stroke ☐ Tremor ☐ Seizure ☐ Memory loss
- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT ☐ Ear pain ☐Hearing loss ☐Ear noises ☐Nose bleed ☐Sore throat ☐Hoarseness ☐Dental issues
- Cardiovascula ☐ Chest pain ☐Chest pressure ☐Shortness of breath ☐Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood
- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐Heartburn ☐Bloody stool ☐Pain in stomach ☐Ulcers ☐Hepatitis
- Genitourinary☐ Painful urination ☐Frequent urination ☐Bloody urine ☐Kidney stone ☐Incontinence ☐ Sexual difficulty ☐ Infection
- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐ Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐ Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐Rheumatoid arthritis ☐Osteoarthritis ☐Compression fracture ☐Head injury ☐ Neck injury☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus ☐ Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis
- Women only ☐ Irregular periods ☐ Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps ☐ Vaginal discharge ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram ___________
- Men only ☐ Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty urinating
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts ☐ Suicidal ideation ☐ Homicidal ☐ Hallucination ☐ Psychosis ☐ Other _______________

Past Medical History

- Heart ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐ Valvular disease ☐ Aneurysm ☐ High cholesterol ☐ Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other _______________
- Lungs ☐ Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other _________
- Gastrointestinal ☐ Ulcer ☐ Reflux ☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other _____________
- Kidney ☐ Failure ☐ Stones ☐ Dialysis (When) _____________ ☐ Other ________________
- Endocrine ☐ Diabetes ☐ Hypothyrodism ☐ Hyperthyroidism ☐ Other _______________
- Neuro ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia ☐ Seizures ☐ Parkinson's ☐ Other __________
- Psychiatric ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other ___________

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- Bone/Muscular ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other _________
- Cancer ☐ ____
- Other ☐ ____

Past Surgery History

____

____

Allergies

- Latex ☐ No ☐ Yes Reaction _____________ • Contrast (Dye) ☐ No ☐ Yes Reaction ________
- Allergic to any medication(s) ? ____

____

Previous Medications (Tried previously but failed to relieve the symptoms & pain)

____

____

Current Medications

____

____

____

Significant Family History (Cancer, hypertension, diabetes, depression, back pain…)

- Father side ____
- Mother side ____
- Siblings ____

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Social History

- Tobacco: □ Never □ Quit in _______ □ Currently ____ pack per day
- Alcohol : □ Never □ Rarely □ Moderate □ Daily_______________
- Use of drugs: □ Never □ Occasionally □ Frequently, Type/frequency ____________
- Marital status: □ Single □ Married □ Separated □ Divorced □ Widowed
- Family status: Living with ____
- Occupation: ____
- Disability: □ No □ Yes (Type) _____________________

This form is completed by

□ Patient X _____________________________________ Date _____________

Medical Marijuana Program in New Jersey

Authorization for Release of Information

Name of Patient _________________________________ Date of Birth ________________

Relievus is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Description of information to be released
Check each person/entity that you approve to receive information.

- Voice Mail
  ☐ Results of lab tests/x-rays
  ☐ Other____
- Spouse (provide name & phone number)_______________________________________
  ☐ Financial
  ☐ Medical as follows:____
- Parent (provide name & phone number) _______________________________________
  ☐ Financial
  ☐ Medical as follows:____
- Other (provide name & phone number) ____
  ☐ Financial
  ☐ Medical as follows:____

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

____ Date ______________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)

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Notice of Privacy Practices

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.
This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care service. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our web site www.relievus.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician’s practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when have the necessary permission from you to disclose your protected health information. For example, your protected health information is provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician.
Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and Disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your physician may, using professorial judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on out professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situation without your authorization. These situations include:

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Required By Law: We may use or disclose your protected health information to the extent that use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such or disclosures.
Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose protected health information to a health oversight agency got activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit program, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state law.
Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviation, tract products; to enable product recalls; to make repairs replacements, or to conduct post marketing surveillance as required.
Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purpose include (1) legal processes and otherwise required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises or the practice, and (6) medical emergency (not on practice's premises) and it's likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to reasonable anticipation of death. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purpose.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Criminal Activity: Consistent with applicable federal and state law, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Required Uses and Disclosure: Under the law, we must make disclosure to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Medical Marijuana Program in New Jersey

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have the decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. **You have the right to request a restriction of your protected health information.** This means you may ask us not or disclose any part of your protected health information for the purpose of treatment, payment or health operation. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by (**describe how patient may obtain a restriction.)**
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purpose. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain; restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name ____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature ____Date _________________________

Medical Marijuana Program in New Jersey

Note: The registry ID # and the reference # will be given to you in the office if you are determined to be eligible for MMP after the initial evaluation

Online Registration Step by Step Instructions

- **Check-Off List for Qualifying Patients/Caregivers → Go to https://njmmp.nj.gov/ and open Patient Registration page → Complete required information**
- **Enter patient reference number supplied by physician and submit**
- **Complete required patient information**
- **Enter the Alternative Treatment Center of choice**
- **Complete patient certification**
- **Complete required caregiver information (if applicable)**
- **Click "Save and Continue" and review confirmation page**
- **Continue to upload documents for both patient and caregiver (if applicable)**
- **Upload patient and caregiver photograph – Required**
    - ✓ **Photograph must be a recent digital photo taken against a white background; the patient/caregiver shall not wear a hat, glasses or any other item that may alter or disguise the overall features of the face; the patient/caregiver face must take up 70 percent of the picture; and a digital photograph must be in JPEG format, which is the format currently used by most digital cameras.**
- **Document 1 - Government issue photo identification – Required one of the following:**
    - ✓ **Current NJ digital license**
    - ✓ **Current NJ digital non-driver ID card**
    - ✓ **NJ County ID Card**
- **Document 2 - Proof of current New Jersey residency - Required (P.O. Boxes NOT Accepted) one of the following:**
    - ✓ **Utility bill issued in the past 90 days that shows your name at your current address**
    - ✓ **Utility Bills accepted: Gas-Electric-Water-Sewer-Cell Phone-Cable (Television/Internet/Phone)**
    - ✓ **Any correspondence from IRS or NJ State tax office within the last year.**
- **Document 3 – Proof of government assistance - Optional one of the following:**
    - ✓ **NJ Medicaid**
    - ✓ **Food Stamp Benefits**
    - ✓ **NJ Temporary Disability Insurance benefits**
    - ✓ **Supplemental Security Income (SSI) benefits**
    - ✓ **Social Security Disability (SSD) benefits**
    - ✓ **Government assistance pictures for comparison**
- **Save and continue**
- **If applicable, download the caregiver criminal background check form. The Caregiver is required to complete form and follow the attached instructions.**

Medical Marijuana Program in New Jersey

- **The MMP will review your application and supporting documents. All applications will be responded to via e-mail with further instructions for finalizing your application. Approved applicants will be instructed on the MMP e-payment process.**
- **Once notified by the MMP of the fee amount, the patient will be prompted to return to the registry homepage and click on payment (you will need your patient reference number) click submit and complete the required information (as noted by the red asterisk). If submitted correctly, you will receive a transaction confirmation number on the last page.**
- **Denied applicants will be provided instructions on amending your application.**
- **Questions regarding this process will be addressed by contacting the MMP Customer Service Unit at 609-292-0424 or medical.marijuana@doh.nj.gov**

Find an Alternative Treatment Center

Compassionate Care Foundation, Inc.	100 Century Drive Egg Harbor Twp., NJ (609) 277-7547
Greenleaf Compassion Center	395 Bloomfield Ave Montclair, NJ 07042 (973) 337-5670
Garden State Dispensary	950 U.S. Highway 1 North Woodbridge, NJ 07095 (848) 999-2005
Breakwater Alternative Treatment Center	2 Corporate Drive Cranbury, NJ 08512 (732) 703-7300
Foundation Harmony	Location Pending (201) 840-5800
Compassionate Sciences, Inc.	111 Coolidge Avenue Bellmawr, NJ 08031 (856) 933-8700