Five Points Health Center

 Clinic Policies

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Five Points Wellness Center is a medical marijuana recommendation center. A visit to our center does not constitute a doctor-patient relationship for any other reason than to determine if a recommendation for medical marijuana is right for you.

Our doctors are alternative medicine specialist, practicing under their naturopathic or homeopathic and integrative medical licenses. The services we offer are not reimbursed by medical insurance, and we will not offer assistance with filing an insurance claim.

As a matter of policy, our doctors will not consult with you about your medical condition, other than to determine if you qualify for a recommendation for medical marijuana. All of the medical records you submit to us will be placed in your chart. Our doctors do not normally review any medical records older than twelve months. Our doctors will review your presented medical records for the past twelve months to determine if you qualify for a recommendation for medical marijuana. Your medical records will not typically be examined by us for any other diagnoses, disease, or conditions; and should be evaluated more thoroughly by your primary care physician. We reserve the right to consult with your physicians to inform them of your medical care.

Our physicians will complete the necessary Arizona State approved Medical Marijuana Physician Certification form, and issue you a temporary unofficial Marijuana Identification Card. Official Identification Cards are applied for online and issued by the Arizona Department of Health Services.

I have been presented with a copy of the clinics ”Notice of Privacy Policies”, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restrictions concerning my personal medical information. I acknowledge that all of the information supplied by me in person and on the patient information forms is true and correct to the best of my knowledge.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

 (If patient is a minor - signature of parent/guardian)