Wholesome
FAMILY MEDICINE
Naturopathic Primary Care for the Whole Family

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# Agreement to Treat

I understand that the information I have been asked to provide is for the evaluation of my medical condition and to determine if it is a qualifying medical condition approved under the Oregon's Medical Cannabis Program, and if I have not accurately and completely disclosed the requested information, it may adversely impact the provider's ability to diagnose my condition and/or determine whether I qualify for medical cannabis per Oregon's state law.

I certify: [initial each item]
____I certify that the information I am providing is accurate and complete and has been offered only for the purpose of determining if I have a qualifying medical condition.
____I certify that my condition is chronic and debilitating to my quality of life.
____I certify that I am not seeking marijuana for illegal purposes.

I understand: [initial each item]
____ The medical provider, staff or representatives of Wholesome Family Medicine LLC are neither providing, dispensing, nor encouraging me to obtain medical marijuana.

____ The medical provider, staff and representatives of Wholesome Family Medicine are addressing specific questions regarding my qualification for entry into the Oregon's Medical Cannabis program, and unless otherwise stated, are in no way establishing themselves as my medical provider beyond the requested evaluation/consultation. All patients should follow up with their primary care provider or mental health provider as appropriate.

____ Wholesome Family Medicine recommends that all patients follow the advice of their primary care provider and/or mental health provider as appropriate.

____ Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the state. It is my responsibility to see the medical provider to assess the possible continuance of cannabis use beyond the term of approval.

____ I acknowledge that I am a resident of Oregon, I am at least 18 years of age and have not misrepresented any information to Wholesome Family Medicine or if I am under 18 I am the Legal Guardian of the Patient.

____ I acknowledge that I have voluntarily sought an evaluation from Wholesome Family Medicine and am in no way being coerced to do so.

____ I acknowledge that evaluation does not ensure a medical cannabis card and if a denial is issued, I am not entitled to a refund.

____ I acknowledge the federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 substances are defined, in part, as having 1. a high potential for abuse; 2. no currently accepted medical use in treatment in the United States; and 3. a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution, and possession of marijuana even in states, such as Oregon, which have modified their state laws to treat marijuana as a medicine.

_____. _____
Patient Signature Date

_____. _____
Printed Name Date of Birth