

Office Use Only! MAIL _____ ONLINE _____ Other _____ PC-20 _____ - _____

OV _____ Pkg _____ IPC _____ CC/Not _____ Other _____ Total Pd _____ By _____

User Name:

Password:

Healthy Choices Unlimited Patient Registration Form

Last Name	First Name	Middle Init.
Patient Social Security # (Required by State of CO)	Birth date / / Mo Day Yr	Age Gender M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/>
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> It's Complicated	Cell Phone #	

Email Address

Mailing Address

City	County	ZIP Code
------	--------	----------

Preferred appointment / clinic communications: Email Cell phone Text Home phone US Mail

Occupation	Employer <i>We ask only for care purposes, since your work affects your health.</i>
------------	--

How did you hear about us? Returning Patient Family/Friend Internet /Website Westword Nickel Ads
 Newspaper/Magazine Dispensary or Store name:

About Today's Visit

Visit Type: New Patient Renewal Change Plant Count /Homebound Status Consult only *-go to next section*

How will you apply to the CO Medical Marijuana Registry? <input type="checkbox"/> Apply via US Mail with clinic help <input type="checkbox"/> Apply Online with clinic help <input type="checkbox"/> Apply Myself / No help	Who will grow your medicine? <input type="checkbox"/> Myself <input type="checkbox"/> I Don't Know <input type="checkbox"/> Caregiver name: <input type="checkbox"/> Dispensary name:
---	---

Are you Homebound? (unable to go out alone) <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting more than 6 plants today? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Emergency Contact Information

Local Friend or Relative:	Phone #
---------------------------	---------

Certification / Attestation

1. The above information is true and correct to the best of my knowledge. 2. I understand that I am financially responsible for any balance due.
3. I am at least the age of 18 and I am not currently pregnant. Or I am the parent or guardian of the patient, who is not pregnant to my knowledge.
4. I have reviewed and agree to the Notice of Privacy Practices on the back of this form or posted in the office. 5. I authorize use/release of my health information as required by Healthy Choices Unlimited to provide me with medical care and to assist with my State Medical Marijuana Registry application by electronic means and US Mail.

Signature	Date
-----------	------

Notice of Privacy Practices

This notice describes how personal medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you would like a copy of this notice, please ask and we will give you one.

1. Our pledge regarding medical information

The privacy of your medical information is important both to you and to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our legal duty

The law requires us to

- Keep your medical information private;
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information;
- Follow the terms of the current notice.

We Have the right to

- Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law;
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and disclosure of your medical information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed.

We will not use or disclose your medical information for any purpose other than treatment, assistance applying to the Colorado Medical Marijuana Registry, payment, and reminders – without your specific written authorization. Any specific written authorization you provide may be revoked by you at any time, by writing to us at the address provided at the end of this notice.

For treatment

We may use your medical information to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, caregivers, or other people who are taking care of you. We may share medical information about you to other health care providers you designate to assist them in treating you.

For assistance applying to the Colorado Medical Marijuana Registry

We may use and disclose your personal medical information to the Colorado Department of Public Health and Environment and the Colorado Marijuana Enforcement Division as needed to help you join the Colorado Medical Marijuana Registry and associated programs.

For payment

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For reminders

We may call, email, text, or send you mail and/or messages regarding appointments, annual visits, follow-ups, and reminders.

4. Your individual rights

You have the right to

- Look at or get copies of certain parts of your medical information. You must make your request in writing.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request that we communicate with you about your medical information by different means or at different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us:

Martha Montemayor, General Manager
Healthy Choices Unlimited
755 North Ave, Unit D
Grand Junction CO 81501

Consent for Medical Evaluation Regarding Cannabis

I, (print name) _____, am at least the age of 18; or am the parent or guardian for the patient. I believe that I, or my child, have at least one of the debilitating or disabling medical conditions or symptoms listed below, as defined by the Colorado state constitution or laws. I further believe that Medical Marijuana, also known as cannabis, may help ease my or my child's condition(s) or symptom(s). I have attempted to obtain and provide copies of relevant medical records regarding any previously diagnosed debilitating medical condition(s) or symptom(s).

Check the condition(s) or symptom(s) below for which you seek treatment with medical cannabis.

I have been diagnosed with and am currently in treatment for one of the following

Debilitating Medical Conditions: Cancer Glaucoma HIV or AIDS

I have a medical illness – or a current medical treatment – that causes one or more of the following
Debilitating Medical Symptoms:

- Severe pain - including (but not limited to) arthritis, migraines, back pain, neck pain, knee pain, accident recovery, post-operative pain, gout, neuropathy, fibromyalgia, abdominal pain, TMJ, etc.
- Severe nausea - including (but not limited to) side-effects from medications, such as antidepressants, anti-anxiety meds, sleep aids, etc.
- Seizures - including epilepsy
- Persistent muscle spasms - including multiple sclerosis, essential tremor, etc.
- Cachexia - physical wasting, with weight loss and muscle loss

I have been diagnosed with and/or am currently in treatment for one of the following
Disabling Medical Conditions:

- ASD – Autism Spectrum Disorder
Name diagnosing Dr or health professional _____
- PTSD – Post Traumatic Stress Disorder
Name diagnosing Dr or mental health professional _____
- Pain for which I would otherwise use an opiate / I want to stop using opiates

I understand that I am consulting with a physician to obtain an opinion as to whether or not I might benefit from the medical use of cannabis. In performing an evaluation of my medical condition as it relates to determining if I might benefit from medical use of cannabis, a bona fide physician-patient relationship is established for the purpose of fulfilling the physician's role as defined in the Colorado Medical Marijuana Amendment. Our physicians advise you to consult both with us and with your primary care provider at least once a year to re-evaluate your debilitating medical condition.

I understand if the physician's opinion is that medical use of cannabis may benefit me, the decision to use cannabis is still at my sole discretion as a patient, and that HCU providers assume no liability for my use of cannabis. If I choose to use cannabis, I understand that cannabis may cause side effects, such as drowsiness, dizziness, decreased reaction time, and decreased coordination, and I must avoid hazardous activities, such as driving a vehicle and operating heavy machinery, when using medical marijuana. I understand that, as with any drug, there is a risk of dependence or addiction. Our physicians in no way imply or recommend that you purchase medicinal cannabis from any specific dispensary or caregiver. If I plan to become pregnant or breastfeed, I will tell the physician and discuss the potential risks that cannabis poses to my unborn or newborn baby.

Signature _____

Date _____

Name _____

Do you need help filling out forms? Y N Name of person Helping if Y: _____

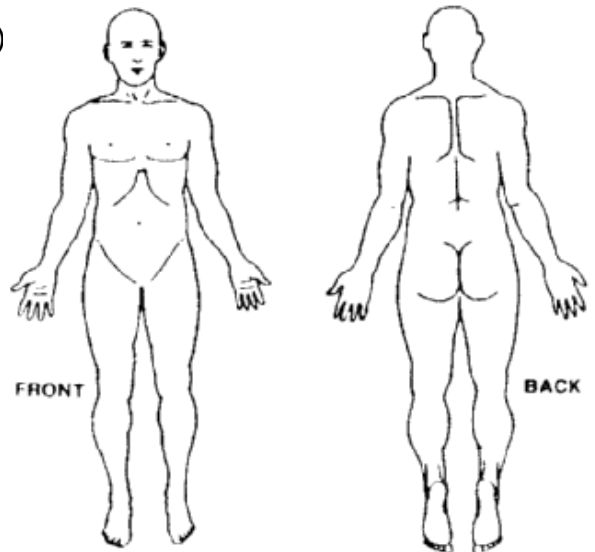
Date of Birth _____ Age Today _____ Are you pregnant? Yes _____ No _____ Maybe _____

Your major health issues

- 1. _____ Date began? _____ How Began? _____
- 2. _____ Date began? _____ How Began? _____
- 3. _____ Date began? _____ How Began? _____
- 4. _____ Date began? _____ How Began? _____

Your past medical history (Include Illness, Injuries, Surgery, etc)

Mark your areas of Pain



Medications Tried: Pain Medications Muscle Relaxants
 Anti-inflammatories Steroids Anti-Depressants Anti-anxiety Sleep Aids Biologics Other

Medications Tired:

Current Medications:

Allergies to Drugs or Foods: None Yes _____

Other therapies tried: Ice / Heat Massage Acupuncture Chiropractic Physical Therapy Yoga
 Pool Therapy Tens Unit Hot tub Splints /wraps Orthotics/Insoles Cane/Walker
 Injections of: pain killers Steroids Nerve blocks Other: _____

Current non-drug treatments _____

Your primary physician or clinic _____ Phone _____

Do you have Health Insurance? Yes – Company: _____ No

Our clinic does NOT bill insurance for medical cannabis evaluations. We do NOT report any information to your insurance company. We ask for in-office care information only. Should you wish to file insurance / HSA claims yourself, ask us for an itemized bill.

Patient Signature _____ Date _____

Provider Reviewed _____ Date _____

EVERYBODY

Pain when at its Worst: None 1 2 3 4 5 6 7 8 9 10 I don't have pain

Do you have trouble with Sleep Yes No If Yes, is problem: Falling sleep Staying asleep Both

Are you able to sleep at least 6 hours at a time? Yes No

How many hours do you sleep per night: None 1 2 3 4 5 6 7 8 9 10+

How many times do you wake up during the night: None 1 2 3 4+

Tobacco use? Yes No If Yes, how much? _____ Alcohol use? Yes No If Yes, how often? _____

Is reducing use of prescription drugs, over-the-counter drugs, tobacco or alcohol a goal for you? Yes No

Cannabis Use

Have you tried cannabis before? Yes No If No, skip to end. If Yes, carry on.

How long have you been using cannabis? _____

Pain Patients - Pain level at its worst without cannabis: None 1 2 3 4 5 6 7 8 9 10

Pain Patients - Pain level when using cannabis: None 1 2 3 4 5 6 7 8 9 10

Check forms most commonly used:

- Smoke /flower Vaporize Concentrates Edibles Capsules Tinctures Salves Patches
- CBD Mostly THC Mostly Combine CBD & THC Other _____

Describe your current cannabis use for your medical condition (Example: 20mg THC edible nightly at bedtime, smoke after work about 1/2 oz per week, use CBD salve on knees during day)

Are you getting adequate relief from the above listed cannabis treatment regimen? Yes No

Estimate how much you use per week: Flower _____ Edibles _____ Concentrates _____

Other _____

How has cannabis helped your quality of life? (examples: less pain, better sleep, fewer seizures, etc)

Have you been able to reduce or stop other drugs since starting cannabis? Yes No

How do you get your cannabis? Shop at dispensary Grow/make my own Caregiver _____

Other comments:

Patient Signature _____ Date _____

Provider Reviewed _____ Date _____

Medical Marijuana Registration Adult Application

All fields in Step 1, 2, and 3 are required for all applicants. Section 1 is required for legal representatives applying on behalf of adults.

Applications will not be approved if they are missing a signature or required information listed on the instruction page.

I am a: Renewal applicant First time applicant

I am applying for: Myself Another as a legal representative

Step 1 Patient information Required

Legal first name		Middle initial	Legal last name and suffixes	
Date of birth (mm/dd/yy)	Social security number (xxx-xx-xxxx)		Sex (as it appears on your driver's license or identification card) <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X	
Mailing address (your card and all correspondence from the registry will be mailed here)				Apt/Ste #
City		CO	Zip code	County
Email			Telephone (000-123-4567)	
<input type="checkbox"/> Copy of my valid Colorado driver's license or ID is attached	Colorado ID number (xx-xxx-xxxx)	Issue date (mm/dd/yyyy)	Expiration date (mm/dd/yyyy)	

Step 2 Select one cultivation option Required

I will get all of my medical marijuana from a center (dispensary).

A caregiver will grow all of my medical marijuana.

I will grow all of my medical marijuana.

A center and I will grow my medical marijuana.

- Center will grow ____ (number) of plants and ____ oz.
- I will grow ____ (number) of plants and ____ oz.

A caregiver and I will grow my medical marijuana.

- Caregiver will grow ____ (number) of plants and ____ oz.
- I will grow ____ (number) of plants and ____ oz.

Caregiver information

Leave blank if you don't have a caregiver

<input type="checkbox"/> I have a cultivating caregiver.	Caregiver legal first name	Caregiver legal last name and suffixes
	Date of birth (mm/dd/yy)	Caregiver registration ID number
<input type="checkbox"/> I have a transporting caregiver. Only patients who are minors, homebound or have a legal rep.	Caregiver legal first name	Caregiver legal last name and suffixes
	Date of birth (mm/dd/yy)	Caregiver registration ID number
What benefits does your caregiver provide for your health and well-being?		<input type="checkbox"/> Copy of my caregiver's valid Colorado driver's license or ID is attached

Step 3 Sign Required

I, (the patient, parent, or legal representative) hereby certify that I have verified the above information to be accurate and complete and no one other than me is submitting this request. I authorize the Medical Marijuana Registry to contact me using the telephone number and address I provided, and understand all correspondence from the Registry will be through postal mail. I understand incomplete applications will not be accepted.

Patient or authorized representative's signature	Date
--	------