CENTER FOR MEDICAL CANNABIS EDUCATION

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number: _____
___Please do not phone me at work. Use this alternate phone number: _____
___Please do not leave messages on my voice mail.
___Please do not contact me by email.
___Please send mail, including my bills, to this alternate address: _____

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 the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully 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 at any time by contacting: Center for Medical Cannabis Education, 731 S. Hwy 101, Suite 1M, Solana Beach, CA 92075, 858-367-0393

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature Date

The Center for Medical Cannabis Education
740 Garden View Court, Suite 207
Encinitas, CA 92024
p: 858-367-0393
info@centerformedicalcannabis.com

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INFORMED CONSENT

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor, other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, botanical medicines, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with Dr. Jamie Corroon the nature and purpose of naturopathic treatments and other procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor from minor to fatal.

The botanical medicines, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that one follow the prescribed recommendations when taking botanical medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that some botanical medicines and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatments prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed) _____

PATIENT SIGNATURE _____Date: _____ (or Patient Representative) Indicate relationship if signing on behalf of patient

_____

A copy of this consent form will be provided upon request.

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PERSONAL INFORMATION

1. First Name:
2. Last Name:
3. What do you prefer to be called?
4. How did you hear about Dr. Corroon?
5. Telephone Number:
6. What telephone number did you provide (e.g., Mobile, home, etc.)?
7. May we leave voice mail messages for you at the telephone number provided for matte other than scheduling and appointment reminders? Y/N
8. What is your preferred email address?
9. May we email you at this email address for matters other than scheduling and appointment reminders? Y/N
10. What is your date of birth?
11. What is your physical address?
12. What is your city?
13. What is your state?
14. What is your zip code?

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ALLERGIES, MEDICATIONS AND DIETARY SUPPLEMENTS

15. Allergies:

16. Medications:

17. Dietary Supplements:

CURRENT SYMPTOMS AND/OR MEDICAL CONDITIONS

18. Please list the symptom(s) or medical condition(s) for which you are interested in using cannabis.

PAST MEDICAL HISTORY

19. Please list all the medical conditions, including surgeries and diagnoses, that you have experienced in the past.