From: AR Center (Arkansas Center for the Study of Integrative Medicine)

PLEASE READ FIRST!

Please be sure that you have a QUALIFYING MEDICAL CONDITION for Medical Marijuana in Arkansas.

If you do not have a Qualifying Medical Condition, we cannot schedule an appointment for you for this clinic.

You MUST be a resident of ARKANSAS to be able to get a state issued registry identification card.

Please note: When you request that clinic notes be sent to us, please request clinic notes that are less than one year old.

Betsy Hendricks MD
Arkansas Center for the Study of Integrative Medicine
Office located at: 505 Amity Road #604, Conway AR 72032
web: www.betsyhendricksmd.com
email: ar_center@myupdox.com
Phone: 501-327-2967
Fax: 501-400-7931

Medical Marijuana

Patient Application Checklist

1. Please read the **General Information and Rules**.

2. What is your Qualifying Medical Condition? _____

3. Fill out the Application.

4. Send the Completed Application (and clinic visit deposit [non-refundable]) in the enclosed envelope.

5. Contact either your Primary Care Physician or the Specialist that has given you the diagnosis that is the Qualifying Medical Condition. Take or send the RELEASE OF INFORMATION form to them. We MUST have this form at our office to be able to schedule your clinic visit. The requested information can either be FAXED or MAILED from the doctor's office. For legal purposes regarding Medical Certification for Medical Marijuana, we cannot accept copies of clinic notes that are hand-carried by the patient.

6. Fill out the Office Forms and Medical History Forms that are included with this packet. You must bring these with you to your visit.

7. Plan to bring a Photo ID with you to your clinic visit.
We will make a copy of this Photo ID at the time of your visit.
You must bring the original Photo ID with you. Do NOT bring a copy of your photo ID.

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Medical Marijuana

General Information and Rules

1. I cannot be your Primary Care Physician.
2. An appointment with me does NOT guarantee that you will receive a Written Certificate of Medical Need for Medical Marijuana. The appointment is our time to review your medical condition, your medical history and to determine if Medical Marijuana is appropriate for you.
3. If you have medical conditions and/or medications that are absolute contraindications for Medical Marijuana, you will NOT receive a Written Certificate of Medical Need for Medical Marijuana. We may be able to determine this before your initial review, in which case, we will not even schedule an appointment to review your case.
4. If you have medical conditions and/or medications that will require monitoring while taking Medical Marijuana, then we may have to schedule further clinic visits. This will be determined at the time of your initial review.
5. If you have a medical condition that is on the list of "Qualifying Medical Conditions" but Dr Hendricks determines that it is NOT advisable for you to have a Written Certificate of Medical Need for Medical Marijuana, then you will NOT receive a Written Certificate of Medical Need for Medical Marijuana. You can, however, discuss this with another health provider.
6. Pediatric patients will require close monitoring and may involve frequent office visits. This will be determined at the time of your initial review.
7. You must request, from your primary care provider or specialist, a copy of your most recent clinic note that contains documentation of a "Qualifying Medical Condition". You may use the Medical Information Release form from our office. The requested information MUST BE FAXED or MAILED to our office from the provider. We will NOT accept documentation that is brought by the patient or family. This is to provide medical/legal protection for our office.
    1. In addition to Item 7, Patients with a diagnosis of PTSD will need to provide a copy of their evaluation from a Psychologist or Psychiatrist.
8. Once we have the requested documentation, we will contact you to schedule your visit with Dr Hendricks.
9. Balance of Payment is due at the time of the visit. Payment is for the CLINIC VISIT, not for the Written Certificate of Medical Need for Medical Marijuana.
10. The clinic visit is not billable to insurance.

Please note: When you request that clinic notes be sent to us, please request clinic notes that are less than one year old.

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Qualifying Medical Condition means one (1) or more of the following:

(A)
Cancer,
Glaucoma,
Positive status for human immunodeficiency virus/acquired immune deficiency syndrome,
Hepatitis C,
Amyotrophic lateral sclerosis,
Tourette's syndrome,
Chrone's disease,
Ulcerative Colitis,
Post-traumatic stress disorder,
Severe arthritis,
Fibromyalgia,
Alzheimer's disease,
or the treatment of these conditions:

(B)
A chronic or debilitating disease or medical condition or its treatment that produces one (1) or more of the following:
Cachexia or wasting syndrome,
Peripheral neuropathy,
Intractable pain (pain that has not responded to ordinary medications, treatment , or surgical measures for more than six (6) months,
Severe nausea,
Seizures, including without limitation those characteristic of epilepsy,
Severe and persistent muscle spasm, including without limitation those characteristic of Multiple Sclerosis:

(C)
Any other medical condition or its treatment approved by the Department of Health under Section 4 of the Medical Marijuana Amendment.

Medical Marijuana Clinic patient application for the AR Center.

Before you fill out the application, please review the following information.

Terms and Payment Policy

1. The clinic visit to determine eligibility for a Written Certificate of Medical Need for Medical Marijuana is not billable to insurance and no insurance billing codes will be provided.

2. The cost of the visit is $200.
A $100 non-refundable deposit is required for scheduling the appointment.
The balance of $100 is due at the time of the visit.

The $100 non-refundable deposit should be either
* check
* money-order
* cashiers check

3. If it is determine by Dr Hendricks that you have NOT provided a valid Qualifying Diagnosis on your APPLICATION, then the $100 deposit will be returned to you and a visit for this clinic will not be scheduled.

4. We will send you the date and time of your appointment. We will give you information on the steps to take if you have to change the date/time of your scheduled appointment.

Betsy Hendricks MD
Arkansas Center for the Study of Integrative Medicine.

Please complete the following application and mail it with the non-refundable deposit to:

AR Center
505 Amity Road, #604
Conway AR 72032

Medical Marijuana Clinic patient application for the AR Center.

Date: _____

01 - Name by which the patient prefers to be called:_____

02 - Last Name (patient): _____

03 - First name (patient) and middle initial:_____

04 - Date of birth:_____

05 - Age of Patient:_____

06 - Name of Guardian. If this does not apply to you, enter "none": _____

_____

07 - Guardian relationship to patient. Enter "none" if this does not apply: _____

_____
08 - Are you a Medicare Patient? _____

09 - Primary Contact Phone Number: _____

10 - Address:_____
11 - City, State and Zip:_____

12 - Email address:_____

13 - What is your QUALIFYING MEDICAL CONDITION (please refer to the page which lists the conditions from the Arkansas Medical Marijuana Amendment)?

_____

14 - How long have you had this/these condition(s)? _____

15 - Please enter your name _____

16 - To proceed with the application, please indicate that you have read and agree to abide by the Terms and Payment Policy.

[ ] Agree

[ ] Non-refundable deposit of $100 is enclosed with this application.

_____ _____
signature date

Arkansas Center for the Study of Integrative Medicine
Seeing patients by appointment only.
Mailing address: 505 Amity Road, STE 604, Conway AR 72032
Phone: 501-327-2967 Fax: 501-400-7931

Release of Information

I hereby give my authorization for the Arkansas Center for the Study of Integrative Medicine to use my Protected Health Information to carry out treatment/payment of any other health care operations.

I understand that my Protected Health Information is as follows:
Information that is oral or recorded in any form that relates to my past, present or future physical or mental health conditions, my past, present, or future health care treatment, that does or could reasonably identify me and is transmitted in an electronic form or maintained in any form. This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

__X__ Last visit only. Clinic notes that reflect current medical conditions.

Please transfer records:

TO

AR Center for the Study of Integrative Medicine
505 Amity Road, STE 604
Conway AR 72032
FAX: 501-400-7931

FROM

_____
_____
_____

Phone: _____

Fax: _____

I understand that I have the right to revoke my authorization however, it shall not be considered revoked to the extent my Health Care provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information. I request this authorization expire on the following date: _____, or I request that this authorization never expire. I may revoke it sooner in writing by contacting the office that is releasing the information. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

_____ _____
Patient - Printed Name Parent/Guardian of Patient

_____ _____
Patient - Date of Birth Today's Date

_____
Patient - Signature (if 18 or older)

All of the Following Forms

should be

Filled Out and

Brought with you when you

COME TO CLINIC.

Name: _____

Date of Birth: _____

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Medication Allergies and Reactions

Medication	Reaction

Do you have any food sensitivities, food allergies or other allergies? Please list these below.

Item	Reaction

Name: _____

Date of Birth: _____

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Medications

Medication	Tab/Cap/Liq/Crm/Pwdr	Dose	Instructions
Example medication	Tablet	25 mg	1 twice daily

Name: _____

Date of Birth: _____

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Supplements

Supplements	Tab/Cap/Liq/Crm/Pwdr	Dose	Instructions
Example supplement	Tablet	25 mg	1 twice daily

Name: _____

Date of Birth: _____

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Medical History - Conditions

Conditions	How long have you had this condition?	Current Treatment

Name: _____

Date of Birth: _____

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Medical History - Surgical History

Surgeries	How old were you OR when was the surgery done?	Why was the surgery done?

For Women: OB/Gyn History

How many children have you had? _____

Any complications of pregnancies or deliveries?

Are you: Pre-menopausal, still having periods Post-menopausal

Name: _____

Date of Birth: _____

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Family Medical History

Relative	Age or Age when died	Medical condition (and cause of death if deceased)
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sibling (M / F)		
Sibling (M / F)		
Sibling (M / F)		
Sibling (M / F)		
Sibling (M / F)		
Child (M / F)		
Child (M / F)		
Child (M / F)		
Child (M / F)		
Child (M / F)		

Name: _____

Date of Birth: _____

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Height: _____ **Weight**: _____

Blood Pressure: _____
(If you do not have a blood pressure cuff, many pharmacies will have one available for customer use.)

Medical History - Social History/Diet

Are you? Married Single Divorced Widowed

Do you have a caregiver, or are you able to take care of yourself? Caregiver Self

What type of work do you do? _____

How long have you done this type of work? _____

What other types of work have you done in the past? _____

_____

How many people are in your home? _____

What type of exercise/activities do you participate in on a regular basis?

_____

Do you smoke or use tobacco in any form? yes no
If "YES", how many packs per day? _____ **and how many years?** _____

Do you drink alcoholic beverages? yes no
If "YES", how much? _____ **and how often?** _____

What do you typically eat for breakfast?

What do you typically eat for lunch?

What do you typical eat for supper?

Name: _____

Date of Birth: _____

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Private Contract with Medicare Beneficiary

INSTRUCTIONS: *If you do not have a contract with medicare, then write "N/A" in the first blank and initial on the signature line.*

The agreement is between Dr Betsy Hendricks ("Physician") of the Arkansas Center for the Study of Integrative Medicine and _____ ("Patient"), who is a Medicare Part B beneficiary. Physician has informed Patient that Physician has opted out of the Medicare Program.
Physician agrees to provide medical services to Patient.
Fee Schedule: $200 for clinic visit related to Medical Certification for Medical Marijuana.
Patient also agrees, understands and expressly acknowledges the following:

1. Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the medical services, even if covered by Medicare part B.
2. Patient is not currently in an emergency or urgent health care situation.
3. Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges of the medical services.
4. Patient acknowledges that MediGap plans will not provide payment or reimbursement for the medical services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
5. Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
6. Patient agrees to be responsible to make payment in full for the Services and acknowledges that Physician will not submit a claim for the Services and that no Medicare reimbursement will be provided.
7. Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
8. Patient acknowledges that a copy of this contract has been made available to him or her.
9. Patient agrees to reimburse Physician for any costs and reasonable attorney fees that result from violation of this Agreement by Patient or his/her beneficiaries.

Executed on _____(date) by _____ and Betsy Hendricks MD

_____(patient signature)

_____(physician signature)

Name: _____

Date of Birth: _____

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Office Policies

Welcome to the Arkansas Center for the Study of Integrative Medicine. We will make every effort to ensure that we provide you with the best possible care. We have policies in place to ensure your privacy and the privacy of your medical information. Every person that enters this clinic is to be treated with courtesy and respect. We expect that every one of our staff is to be treated the same way.
To be able to provide consistent, high-quality care, we ask that you read and agree to the following:

- Please be on time for your scheduled appointment. We make every effort to stay on schedule so that each person can have the necessary time with Dr Hendricks.
- Please provide us with at least 24 hours notice if you are going to be unable to keep your scheduled appointment. Call us at 501-327-2967.
- Dr Hendricks does not provide hospital care. Dr Hendricks DOES NOT DO EMERGENCY CARE.
- Please maintain a clinical relationship with a primary care physician.
- Payment is expected at the time of your visit.
- We do NOT file insurance. We are NOT on any insurance plan.
- We must have your permission to release any of your information to another party.
- Please do not wear perfumes, colognes, essential oils or other fragrances to the office. Many of our patients have severe olfactory sensitivities.
- Please turn off all cell phones or other auditory devices during your consultation with Dr Hendricks.

Signature of responsible party _____

Date _____

Name: _____

Date of Birth: _____

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Consent: Evaluation and Treatment Recommendations

I consent to medical evaluation by Betsy Hendricks MD. I understand that she and I will discuss my medical condition and that she will make treatment recommendations based on my personal medical history, family medical history and present medical condition.

Signature of responsible party _____

Date _____

Name: _____

Date of Birth: _____

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Consent: Release of Information to Family/Friends

This is optional. You do not have to give us permission to discuss your information with anyone else.

I, _____ allow Betsy Hendricks MD and her staff at the Arkansas Center for the Study of Integrative Medicine to discuss my condition, appointments, medications and other necessary medical information with the following persons:

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

Signature of responsible party _____

Date _____

Name: _____

Date of Birth: _____

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Patient Information Sheet with Emergency Contact

Patient Mailing Address	
City, State Zip	
Phone	
Email	

Bill to	
Mailing Address	
City, State Zip	
Phone	
Alternate Phone 1	
Alternate Phone 2	
Email	

Emergency Contact	
Mailing Address	
City, State Zip	
Phone	
Primary Care Physician	
PCP Phone number	