THANK YOU FOR BEING HERE!

We are honored you've chosen us to be your medical cannabis (marijuana) provider.
We look forward to getting to know you.
Please tell us a little about you and your history with medical cannabis.

PART 1 — PERSONAL INFORMATION *required*

FULL NAME

NICKNAME

HOME ADDRESS

CITY

STATE

ZIP

MOBILE NO.

HOME PHONE NO.

EMAIL

YES, I WOULD LIKE TO RECEIVE INFORMATION, COMMUNITY UPDATES, AND SPECIAL OFFERS
WE PROMISE WE WILL NOT SELL OR SHARE YOUR CONTACT INFORMATION
☐ Email ☐ Text ☐ Decline

BIRTH DATE

BIRTH GENDER
☐ Female ☐ Male ☐ Other ☐ Decline

OCCUPATION

FINANCIAL HARDSHIP
☐ Yes ☐ No

VETERAN
☐ Yes ☐ No

SENIOR
☐ Yes ☐ No

PATIENT ID NO.

PATIENT ID EXPIRATION

PATIENT CERTIFICATION NO.

CERTIFICATION EXPIRATION

PRACTITIONER NAME

PRACTITIONER PHONE NO.

CAREGIVER NAME, IF APPLICABLE

CAREGIVER PHONE NO.

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PART 2 — MEDICAL HISTORY *required*

1. ANY KNOWN ALLERGIES?

2. CURRENT MEDICATIONS? (PRESCRIPTION & NUTRITIONAL SUPPLEMENTS)

Name of Medication	Dosage	Frequency

3. ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOU?

PART 3 — MEDICAL CANNABIS HISTORY *optional*

1. WHY HAS MEDICAL CANNABIS BEEN RECOMMENDED TO YOU?

2. WHAT MEDICAL CANNABIS HEALTH INDICATION DO YOU EXPERIENCE? indicate below

- ☐ Chronic Pain
- ☐ Cancer Pain
- ☐ Neuropathy
- ☐ Huntington's Disease
- ☐ Parkinson's Disease
- ☐ Epilepsy
- ☐ Spinal cord injury with spasticity
- ☐ Post-traumatic Stress Disorder (PTSD)
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Multiple Sclerosis (MS)
- ☐ HIV/AIDS
- ☐ Inflammatory Bowel Disease (IBD)

3. HOW LONG HAVE YOU BEEN USING MEDICAL CANNABIS? select one

- ☐ Never used medical cannabis before
- ☐ Less than 1 year
- ☐ 1 – 3 years
- ☐ 3 + years

4. DO YOU HAVE A PREFERRED METHOD OF CONSUMPTION? select one

- ☐ Yes
- ☐ No
- ☐ Need Recommendation

5. IF YES, PLEASE SELECT YOUR FAVORITE METHOD BELOW.

- ☐ Tablets
- ☐ Capsules
- ☐ Vaporizing Concentrates
- ☐ Tinctures
- ☐ Topicals
- ☐ Other _____

6. HOW DID YOU HEAR ABOUT US?

- ☐ Doctor
- ☐ Drive/Walk By
- ☐ Facebook
- ☐ Twitter
- ☐ Word of Mouth
- ☐ Newspaper
- ☐ WeedMaps
- ☐ Other _____
- ☐ Leafly
- ☐ Radio
- ☐ MassRoots

thank you

PRIVACY PRACTICES NOTICE

Required

This notice describes Fp Wellness' privacy practices and how medical information about you is protected and how it may be used and disclosed, as well as how you may access this information. Please review the following carefully.

I. OUR PRIVACY OBLIGATIONS

Fp Wellness chooses to maintain the privacy of medical health information. As a result, all patients are provided with this Notice of our duties and privacy practices with respect to medical health information. When patient medical health information is used or disclosed, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure). A patient-specific log of medical cannabis products dispensed to the patient, including brand, administration form, dosage, dates dispensed, and any return of product, will be provided to the patient's designated caregiver, if applicable, or the patient's healthcare practitioner upon request.

Nothing in these privacy procedures should be construed to voluntarily or involuntarily waive Fp Wellness' requirement to protect your medical health information.

II. PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

In certain situations (described in Section IV below), we must obtain your written authorization in order to use and/or disclose your medical health information. We may also disclose medical health information to your other health care providers when such medical health information is required for them to treat you or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or compliance. However, we do not need any type of authorization from you for the following uses and disclosures:

- Disclosure to Relatives, Close Friends, and Other Caregivers. We may use or disclose medical health information to a family member, other relative, or your designated caregivers as identified by you when you are present for, or otherwise give permission prior to, the disclosure. If you object to such uses or disclosures, please notify the manager on duty.
- Department of Health. We may disclose medical health information as required by Department of Health regulations.
- Judicial and Administrative Proceedings. We may disclose medical health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
- Law Enforcement Officials. We may disclose medical health information to the police or other law enforcement officials, as required or permitted by law or in compliance with a court order, a grand jury, or administrative subpoena.
- Health or Safety. We may use or disclose medical health information to prevent or lessen a serious and imminent threat to a person or the public's health or safety.
- As Required by Law. We may use and disclose medical health information when required to do so by any other law not already referred to in the preceding categories.

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III. USE AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than those described in Section II, we may only use or disclose medical health information when you provide us your authorization.

IV. YOUR INDIVIDUAL RIGHTS

- Further Information or Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that made about access to medical health information, you may contact the manager on duty.

- Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of medical health information to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care. All requests for such restrictions must be made in writing. While all requests for additional restrictions will be considered carefully, we are not required to agree to a requested restriction.

- Right to Receive Confidential Communications. You may request to receive written medical health information by other means of communication or at alternative locations and can expect to be accommodated for any reasonable request.

- Right to Inspect Your Purchase History. You may request access to your purchase history.

- Right to Revoke Your Authorization. You may revoke your authorization or your special authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the manager on duty.

- Right to Amend Your Records. You have the right to request that we amend medical health information maintained in your patient profile. If you desire to amend your records, please submit a request in writing to the manager on duty. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

- Right to Receive Paper Copy of this Notice. You may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

V. EFFECTIVE DATE AND DURATION OF THIS NOTICE

Effective Date. This Notice is effective on December 1, 2018.

Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all medical health information that we maintain, including any information created or received prior to issuing the new Notice. If we change this Notice, we will post the revised notice in waiting areas of the dispensaries. You may also obtain any revised notice by contacting the manager at the Dispensary.

By signing below, I hereby acknowledge receipt of the Fp Wellness' Notice of Privacy Practices.

Patient's Signature: _____ **Date:** _____

thank you

CODE OF CONDUCT AGREEMENT

AS A CUSTOMER OF THIS DISPENSARY, I UNDERSTAND AND AGREE TO THE FOLLOWING:

- For the protection of our customers' privacy and for security reasons, no photography or video recording are permitted in the dispensary.
- I will not consume food or beverages on the sales floor during hours that cannabis (marijuana) is being dispensed, unless necessary for medical reasons.
- I will not loiter outside of the dispensary before or after completing a transaction.
- I will not consume or vaporize cannabis (marijuana) in the dispensary, the parking lot, or the surrounding area.
- I will not open any cannabis (marijuana) product until I reach my private residence. Open products in the vehicle or in public may violate local and state laws.
- I will not distribute, sell, or share your cannabis (marijuana) products. Doing so violates local and state laws.
- I understand any inappropriate action or language is cause for being asked to leave the dispensary and that repeated offenses will result in permanent refusal of service.

Patient's Signature: _____ **Date:** _____

Caregiver should sign separate Code of Conduct Agreement

FOR EMPLOYEE USE ONLY:

◇ Patient ID Verified ◇ ID Expiration Date Verified

◇ Patient Certification No. Verified ◇ Certification Expiration Date Verified

Employee Name: _____ **Employee No:** _____

Employee's Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I,_____,authorize Fp Wellness dispensary to disclose and/or release my protected health information and/or purchase information as described below to:

Name:_____Relationship (Self/Caregiver): _____

Phone: _____

Address: _____

INFORMATION TO BE DISCLOSED upon the request of the person named above:

_____

_____

_____

_____

FORM OF DISCLOSURE initials:

_____ Verbal

_____ Electronic Record

_____ Hard copy

THIS AUTHORIZATION SHALL BE EFFECTIVE UNTIL initial one:

_____ All past, present, and future periods, OR

_____Date or event:_____unless I revoke it.

NOTE: You may revoke this authorization at any time by notifying the dispensary, preferably in writing.

_____

Name of the Individual Giving this Authorization **Date of Birth**

_____

Signature of the Individual Giving this Authorization **Date**