WE ARE NOW OFFERING

MEDICAL MARIJUANA

A patient can be certified to use medical marijuana if they suffer from:

- Epilepsy / Seizures
- Parkinson Disease
- Multiple Sclerosis (MS)
- Post-Traumatic Stress Disorder (PTSD)
- Amyotrophic Lateral Sclerosis (ALS)
- Glaucoma
- HIV/AIDS
- Cancer
- Crohn Disease
- Chronic Nonmalignant Pain from a condition listed above
- A Terminal Condition
- Medical Conditions of the same kind or comparable to those above

These may include:

Chronic Pain	Muscle Spasms
Headache	Insomnia
Migraine	Fibromyalgia
Stress	Rheumatoid Arthritis
Anxiety	Frequent Urination

How to become certified to use medical marijuana:

- Schedule an appointment with a certified physician.
- If you qualify you will be issued a certification.
- Once you have applied for and been approved for your Medical Marijuana Use Registry ID Card (https://mmuregistry.flhealth.gov), your physician will place an order for Low-THC (CBD) and/or Medical Marijuana products.
- Obtain Medical Marijuana products from any dispensary.

Volusia Natural Wellness

Jeffrey S Corak, MD

760 S Volusia Ave, Suite 400
Orange City, FL 32763
Tel (386) 774-0308 ▪ Fax (386) 774-0961
www.volusianeurology.com/medicalmarijuana

Dear Patient:

You have an appointment scheduled with Dr Jeffrey Corak. We have enclosed patient information forms to be completed and brought to your appointment. Please also bring all medications, pertinent medical records and test results. If the diagnosis for which you are requesting Medical Marijuana has already been made by another physician please bring appropriate documentation.

Please allow one week for initial certification. You will then be contacted via email or phone with the information necessary to register online (https://mmuregistry.flhealth.gov) or by mail with the state. They will send you your ID number within several days which can be used to obtain product from a dispensary even before receiving your ID card which may take up to two weeks. Initial certification is good for 210 days after which you will need to be reevaluated and recertified. Prescriptions are made online and are valid for 70 days. Certification includes two 70-day refills.

The charge for initial certification is $250 and for each recertification $195. If you need to be seen before a recertification the charge is $49. Payment will be due at the time of service.

Should you need to contact us, our office hours are Monday to Friday, 9 am to 5 pm. Messages left for the nurse will be returned within 24 hours.

We also kindly request that you refrain from wearing perfume, cologne or scented lotions in the office.

Should you need to cancel your appointment, please contact our office 24 hours in advance or you will be subject to a missed appointment fee.

We make every effort to be on time and ask that you do the same, but your appointment could be delayed. We ask for your understanding should this occur.

Please feel free to contact our office with any questions or concerns.

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PATIENT INFORMATION SHEET

Date: ________________________________ 20__________

Last Name: ____

First Name: ______________________ Middle Initial: ____

Address: ____

City: ________________________ State: _____ Zip:______

DOB: _________________________ Age: ______________

Home Phone: (______)___________________

Work Phone: (______)___________________

Cell Phone: (______)___________________

Email: _________________________________

SSN: __________________________________

Employer: ____

Address: ____ Phone: (______)_____________________

Pharmacy Name: ____________________________________ Phone: (______)_____________________

Family Doctor: _______________________________________ Phone: (______)_____________________

In An Emergency Notify: ____________________________ Phone: (______)_____________________

If Patient Is A Minor, Parent's Name: ________________________

Please Complete This Form And The Attached Medical Questionnaires And Bring With You To The Office For Your Appointment On: ______________________________ At: _____________________

Office Fees Are Due At The Time Of Service

At Volusia Natural Wellness your well being is our primary concern. In order to offer you the best treatment possible please complete this form as accurately and completely as you can.

Name: ________________________ Age: __________ Weight: __________

Please describe the diseases or symptoms you wish to treat with Medical Marijuana (including other doctors seen, tests done and treatments tried):

____

____

____

____

____

____

Do you suffer from:

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Headaches / Migraine
- ☐ Burning Feet
- ☐ Muscle Spasms
- ☐ Frequent Urination
- ☐ Leg Pain
- ☐ Arm / Hand Pain
- ☐ Facial Pain
- ☐ Joint Pain
- ☐ Insomnia
- ☐ Stress / Anxiety

List your other medical problems (e.g., High Blood Pressure, Diabetes):

____

____

____

Have you ever had cancer? What kind? ______________________________

List any operations you have had, including dates:

____

____

____

List all medications you are currently taking, including dosages:

____

____

____

____

List any medications you are allergic to:

____

____

Do you smoke? If yes, how much:

Do you drink alcohol? If yes, how much:

Marital status:

Number and ages of children:

What type of work do you (or did you) do:

Are there others in your family with the same problem as you?

List any medical problems in your

mother: father:

siblings: children:

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Acknowledgement of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent. We may refuse to treat you if you do not sign this Consent Form or sign this Consent Form and then revoke it.

I acknowledge and agree that my protected health information and medical record information may be disclosed to the following individuals:

Name:	**Relationship:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I have read and understand the information in this consent.

Patient Name (print): ____

Patient Signature: _________________________________ **Date:** ____________

Witness: ____________________________