Integrative Family Medicine
7468 N. LA CHOLLA BLVD., TUCSON, AZ 85741
PHONE (520) 297-9664 FAX (520) 297-9633

PATIENT'S LEGAL NAME	DATE OF BIRTH	OCCUPATION
MAILING ADDRESS	MARRIED ☐ SINGLE ☐	EMPLOYER
	MALE ☐ FEMALE ☐	
CITY STATE ZIP		
RESIDENCE ADDRESS	EMERGENCY CONTACT	**HOW DID YOUR HEAR OF US?**
CITY STATE ZIP	EMERGENCY CONTACT PHONE	
E-MAIL		
HOME PHONE NUMBER	**RELEASE OF INFORMATION AUTHORIZATION** Please list contacts that have your consent to receive your medical information.	
CELL PHONE NUMBER	Contact me at: ☐Home ☐Work ☐Cell ☐Answering Machine ☐Email	
WORK PHONE NUMBER	Or Contact_____ phone#_____	

PLEASE PRESENT TO THE RECEPTIONIST:

- PHOTO IDENTIFICATION WITH CURRENT ADDRESS AND PHOTO
- Supporting Medical Records for your chief complaint or medical condition, such as X-Rays, CT Scans, MRI's, Surgery Notes, Lab results and etc.
- If applicable, Supplement Nutritional Assistance Program (SNAP) Card or letter with patient's name on card or letter

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To complete the State of Arizona Medical Marijuana online application, you must have specific documents and other items in a digital format ready for upload. We provide a service to process your online application for $30.00.

Would you like us to process your state application? Yes _____ No _____

If yes, please answer the following questions.

Do you have a state licensed medical marijuana caregiver? Yes _____ No _____
(If you are not able to go to the dispensary yourself, you will need a licensed medical marijuana caregiver.)

Are you requesting authorization to cultivate marijuana at your residence address?
Please note: Most Arizonians live within 25 miles of a qualified dispensary and will not be able to cultivate their own marijuana. If yes and you live within 25 miles of a dispensary, you will be running the risk of losing your state application fee. **Yes _____ No _____**

Would you like notification of any clinical studies needing human subjects for research on the medical use of marijuana? Yes _____ No_____

Do you have Supplemental Nutrition Assistance Program (SNAP), aka. Food Stamps? Yes_____ No_____

FINANCIAL ARRANGEMENTS AND TREATMENT POLICY

We feel that everyone benefits when there is a definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control the administrative cost.

Medical Consent

By seeking services from Integrative Medical Associates, you authorize the doctor and practice staff to perform necessary services for the patient named above, any treatment, which is deemed advisable by the doctor. You also agree that all disputes concerning the Medical Consent and the treatment shall be resolved by arbitration, which shall be final and binding, held in Pima County, Arizona according to A.R.S. Title 12, Chapter 9, Article 1, as may be amended from time to time.

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. Copies of the Notice of Privacy Practices are located in our lobby or at the front desk. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please note that by signing below you are acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Appointments

We have exclusively reserved the doctor, nurse, or staff and facilities for your personal health care. We ask our patients to give us a 24 hour notice if you need to cancel or reschedule. If you do not come in for your appointment, or break your appointment without sufficient notice, a $50.00 broken appointment fee will be applied to your account and you will be required to pre-pay for your next appointment.

For IVs and injections, the fee will be the cost of the IV or injection, unless there is an available time slot for the patient to be rescheduled within 48 hours.

If you are scheduled for multiple appointments for the same day, and you do not come in for your appointment, or break your appointment without sufficient notice, a $50.00 per hour broken appointment fee will be applied to your account per each appointment missed and you will be required to pre-pay for your next appointment.

Payments and Fees

All fees are due at the time of service. We accept Cash, Visa, MasterCard and Discover. The fees for quality health care are based on the treatment rendered and the time needed to complete the treatment. Our office believes that the fees are a fair representation of the standard of care we provided and in-step with the industry standard.

Finance Charges

Even though we encourage patients to maintain a zero-balance account, in the event your account is not paid in full, a service fee will be incurred on any unpaid balance that is older than 45 days. The service fee will be a minimum of two dollars or 1 ½ % per month (18% annually) of the unpaid balance which ever is greater. In the event that collection efforts become necessary to collect on your account, you are responsible to pay all costs including collection fees and returned check fees.

Request for Records, Health Savings Letters and Other Forms

Medical Records: It is the policy of Integrative Medical Associates to charge for the processing of medical records relating to purposes other than continuing care, along with requiring pre-payment of these fees. This is in accordance with ARS 12.2295, A., which states that except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records a reasonable fee for the production of the records and may require the payment of any fees in advance. Our fees are set at $25.00 professional fee plus $1.00 per page up to 50 pages, and $.50 per page thereafter.

Letters and Forms: When a patient requests a letter or form to be filled out by the doctor or other staff member, a fee will occur when it is not for a medical necessity. There will be a charge for Health Saving Account forms or letters, disability forms, insurance forms, etc.

Termination of Treatment

You play an important role in your own health care. Just as a patient can choose to discontinue care at any time, Integrative Medical Associates reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans and/or financial policies.

Our office would like to thank you for your time, cooperation and trust in us to deliver comfortable, safe and quality care to you, your family and friends. We also appreciate your understanding in the necessity of the aforementioned guidelines and procedures.

I am the patient, parent, guardian, or personal representative of the person listed on page one of the Financial Arrangement and Treatment policy. There are no court orders in effect that prohibit me from signing this consent. **I have read, understand and will abide by the information concerning these office policies.**

_____ _____

Responsible Party Signature Date

Integrative Medical Associates
PRIMARY CARE . . . NATURALLY

(520) 297-9664 Fax (520) 297-9633
7468 N. La Cholla Blvd.
Tucson, AZ 85741

What is your current chief complaint or medical condition? How long have you had this condition?
Please list the medical problem(s) for which you would like to use medical marijuana:

_____

_____

_____

Treatments: Check any treatments you have used for your condition:____surgery____physical therapy____chiropractic ____massage____nutraceuticals____counseling____excercise____accupuncture other_____

Have you used medical marijuana before? If so, how was it helpful to you?

_____

Hospitalization and Surgical History: list any hospitalizations/ surgeries that you have had (include dates)

_____

_____

_____

Family history: Do your parents, siblings or children have/ had any significant medical/psychological problems? Yes / No

If yes please explain_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the last year.	
GENERAL	**GASTROINTESTINAL**
☐ Headache	☐ Appetite poor
☐ Loss of sleep	☐ Bowel changes
☐ Loss of weight	☐ Constipation
	☐ Stomach pain
MUSCLE/JOINT/BONE	☐ Vomiting
Pain, weakness, numbness in:	☐ Chrohn's Disease
☐ Arms	
☐ Back	**VISION**
☐ Feet	☐ Glaucoma
☐ Hands	

Primary Care Physician_____Phone_____ Last Seen on _____

Address_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Print Patient's Name Patient Signature Date

Dr. Bruce A. Sadilek
7468 N. La Cholla Blvd.
Tucson, AZ 85741
(520) 297-9664
Fax (520) 297-9633

Patient's Medication Sheet

Allergies to medications: Indicate what the allergy causes i.e. hives, rash, nausea, etc.

_____

_____

Patients: Please list your medications, dosages, and directions.			**For Office Use Only**			
			Date	**Date**	**Date**	**Date**
Medications	Dosage	Directions				

I certify, to the best of my knowledge, the above information is correct. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Print Patient's Name _____ Date of Birth _____ Patient's Signature _____

LIABILITY WAIVER AND RELEASE

In consideration of the medical evaluation of me to be performed by or on behalf of Integrative Medical Associates, PC, I, my heirs, assigns and anyone acting on my behalf, agree to hold the Integrative Medical Associates, PC, Staff Physicians, and their principals, agents, officers, directors and employees, free and harmless from any and all claims, damages and causes of action relating to or arising out of: (1) my use or possession of cannabis (marijuana), or (2) the denial of my application for a medical marijuana card for any reason.

I understand and acknowledge that:

1. Integrative Medical Associates, PC is not a Dispensary and cannot provide me with medicinal marijuana or any other medication.
2. An evaluation that results in a physician's recommendation that I may benefit from the use of medicinal marijuana does not guarantee that I will in fact be eligible to obtain, possess or use medicinal marijuana pursuant to Arizona law.
3. A physician's recommendation that I may benefit from the use of medicinal marijuana does not guarantee that the use of medicinal marijuana will be effective at alleviating my pain; or any other medical condition.
4. I acknowledge that my employer or occupation may prohibit me from the use of medical marijuana even though I have state certification.
5. Should an approval be made for my medicinal use of medical marijuana, there is a renewal date specified by the state. It is my responsibility to see the physician to assess the possible continuance of medical marijuana use beyond the term of the approval.
6. I am a resident of Arizona, I am at least 18 years of age and have not misrepresented any information to Integrative Medical Associates, PC.
7. I acknowledge that I am not recording any portion of my visit with Integrative Medical Associates, PC. I understand that IMA, PC does not allow any recordings. Any such action is a direct violation of HIPAA regulations and patient/ doctor confidentiality.
8. I acknowledge that marijuana, even if used for medical purposes, is illegal under Federal law.
9. I acknowledge that the use of medical marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/ or respond quickly. I understand that if I drive while under the influence of medical marijuana, I can be arrested for "driving under the influence".

ACKNOWLEDGED AND AGREED:

Print Patient's Name Patient's Signature Date

PATIENT INFORMED CONSENT AND CONTRAINDICATIONS & SIDE EFFECTS ACKNOWLEDGMENT

Please read and sign in the space provide to indicate that you understand and agree.

I understand that medical marijuana is considered a medicine and is to be used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include:

- Acquired Immune Deficiency Syndrome (AIDS)
- Amyotrophic Lateral Sclerosis (ALS)
- Human Immunodeficiency Virus (HIV)
- Glaucoma
- Post-Traumatic Stress Disorder (PTSD)
- Severe and Chronic Pain
- Seizures, including epilepsy characteristics
- Severe or persistent muscle spasms, including those characteristic of multiple sclerosis
- Crohn's Disease
- Agitation of Alzheimer's Disease
- Cancer
- Hepatitis C
- Cachexia or Wasting Syndrome
- Severe Nausea

If I begin to experience respiratory problems or any other ill effects and I will discontinue the use of medical marijuana.

The Staff Physician is addressing one specific aspect of my medical care for medical marijuana and unless otherwise stated, is not establishing himself as my primary physician unless specifically requested and the proper paperwork is completed.

The Staff Physician is not advising nor condoning the discontinuation of treatment or medication that I am currently taking.

I give my consent to have my name, date of visit and other required information released for the legal verification of my certification as needed.

I have had the opportunity to discuss these matters with the Staff Physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

I understand that smoking marijuana may cause respiratory harm such as bronchitis. Some researchers believe that marijuana smoke contains chemicals that can cause lung disease and that smoking marijuana may increase the risk of respiratory illness and disease of the lungs, throat, mouth and tongue.

<u>Possible side effects of medical marijuana may include, but are not limited to:</u>

- Anxiety
- Inability to concentrate
- Difficulty in completing complex tasks
- Sedation
- Alterations in the perception of time and space
- Impairment of motor skills, reaction time, & physical coordination
- Low blood pressure
- Dizziness
- Increased talkativeness
- Impairment of short-term memory
- Confusion
- Euphoria
- Tachycardia and heart palpitations
- Cough
- Sore throat
- Laryngitis
- Bronchitis
- General Apathy
- Paranoia
- Suppression of the body's immune system
- Psychotic symptoms

I understand that side effects, while rare, may occur while I am using medical marijuana. These side effects have been explained to me.

The potency and effects of medical marijuana varies. Estimating the proper marijuana dosage is very important. Some patients may become dependent on marijuana and could experience withdrawal symptoms when they stop.

<u>Symptoms of withdrawal, while generally mild, can include:</u>

- Feelings of depression, sadness or irritability
- Insomnia
- Sleep disturbances
- Unusual tiredness
- Trouble concentrating
- Loss of appetite

I understand that the cannabis plant is not a food crop and therefore is not regulated by the U.S. Food & Drug Administration and may contain unknown quantities of impurities, active ingredients and/or contaminants. While under the influence of marijuana, the use of alcohol is not recommended. The possibility exists that medical marijuana may exacerbate psychotic problems.

Patient's Name (Please Print) Patient's Signature Date

ARIZONA DEPARTMENT OF HEALTH SERVICES

MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA PATIENT ATTESTATION

I, _____, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

Integrative Medical Associates

Dr. Bruce A. Sadilek
7468 N. La Cholla Blvd.
Tucson, AZ 85741
(520) 297-9664 fax (520) 297-9633
www.DrSadilek.com info@DrSadilek.com

REQUEST FOR AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This form is submitted on behalf of our mutual patient. This is not a notification for transferring care.

Please print clearly:

PATIENT NAME: _____ DOB: _____/_____/_____

TO: Bruce A. Sadilek, N.M.D.
Integrative Medical Associates
7468 N. La Cholla Blvd
Tucson, AZ 85741
Phone (520) 297-9664
Fax (520) 297-9633

FROM:

DOCTOR'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

The patient referenced above has agreed to the release of the following medical information indicated below.

☐ Medical Diagnostic / Problem List ☐ Office and Surgical Reports ☐ Lab & X-ray Results

Period of Time: ☐ Last 12 months only ☐ Entire Records ☐ Other _____

In addition to the general authorization to release records, I may authorize the release of the following information:

DRUG/ALCOHOL ABUSE	MENTAL HEALTH	HIV/AIDS
_____Yes	_____Yes	_____Yes
_____No	_____No	_____No

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by written notice.

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE SIGNED.

SIGNATURE:_____ DATE:_____
Signature of patient or patient's representative

NAME:_____RELATIONSHIP:_____ DATE:_____
Printed name of patient's representative and relation to patient

FOR OFFICE USE ONLY

Faxed on _____ By _____ Confirmed of receipt on _____ By _____

Notes:_____

_____

_____

_____