PEDRO T. OLIVEROS, MD
341 N. Maitland Ave Ste 200 Maitland FL 32751 PH: 321-972-9526 FX: 407-265-2872

Patient Registration Number: _____

Patient Information

Today's date: _____

Name _____ _____ _____ Sex: Male ☐ Female ☐ Wt: _____
Last *First* *M*

Address _____ _____ _____ _____ _____ County: _____
Street *Apt* *City* *St* *Zip*

Email address: _____ Phone number: _____

Date of Birth ____/____/_____ SSN: _____

Emergency Contact _____ Phone: (___) ____-_____ _____

Primary Care Physician _____ Phone: (____) _____ - _____

Legal Representative (optional)

Name: _____ SSN: _____

Address: _____

Phone: _____ Email address: _____

I represent and affirm that I have read and understand the above and, that the information I have provider is true and correct. It is my understanding that Dr. Pedro Oliveros and his staff are relying on this. I have read the Consent for Treatment and other documents on the following pages and as the patient or patient's authorized representative or general agent for the purpose of signing this form, I hereby accept its terms.

_____ _____
Patient Signature or Legal Representative Printed Name and Signature *Date*

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Privacy Policy (Effective April 14, 2003)

Background

Medical offices are required by federal and state laws to maintain confidentiality of medical information generated for patients during their course of treatment. Legislation requires patients to be notified about privacy practices, our legal duties concerning these practices, and your rights concerning your health information. Our goal is to maintain confidentiality of your medical information. There are times, however, when identifiable health information must be disclosed to specific entities such as your insurance carrier. In these cases, we will only disclose information essential to comply with the request.

We reserve the right to change our policy related to health information collected and maintained, including information obtained before policy changes were determined to be necessary. As changes in our privacy practices are made, we will notify our patients of these changes.

In addition to our use of your health information for treatment, payment, or medical practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such authorization, you have the right to revoke it in writing at any time. Your revocation will not revoke any use or disclosures permitted by your authorization while it was in effect.

We may disclose your health information to:

- a family member, friend, or other person the extent necessary to assist us with your medical care or with payment for your medical care, but only if you agree that we may do so.
- when we are required to do so by law through a subpoena.
- to military authorities under certain circumstances
- to correctional institutions or law enforcement officials having lawful custody of protected information of inmates or patients under certain circumstances.

We may disclose medical information of minor patients to appropriate authorities if we have reason to believe that they are possible victims of abuse, neglect, domestic violence, or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Patient Rights

- You have the right to read over or obtain copies of your medical information.
- You have the right to receive a list of instances in which the practice has disclosed medical information for purposes other than treatment, payment, or medical practice operations. If requested more than once in a 6-month period, you will be charged our customary fee for responding to these requests.
- You have the right to request that we communicate with you regarding your medical information or treatment; any such requests must be in writing.
- You have the right to request that we amend the medical information that has been provided to you. Your request must be in writing, and it must give a detailed explanation of why the information should be amended. We reserve the right to deny your request under certain circumstances.

Below please enter names of individuals you would like to disclose any medical information in person

_____ _____

Name / Relation Name / Relation

_____ _____

Patient Signature or Legal Representative Printed Name and Signature Date

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PATIENT FINANCIAL ACKNOWLEDGEMENT

I, _____, understand the following:
(patient or legal guardian)

1. All my visits regarding low treatment with Dr. Pedro Oliveros are not covered by and will not be filed with my insurance company per Florida Statues.

2. I understand that the cost of the initial visit to assess my candidacy for medical marijuana is $200. This includes medical evaluation, certification and order/recommendation (does not include Medical Marijuana Registration Card fee). Follow up visits for refills will be $100.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Authorization for Release of Records

I, _____ hereby authorize Dr. Pedro T. Oliveros' office to obtain records

From _____
(doctor or hospital releasing information)

Address _____

Telephone # _____ Fax # _____

This authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained except to the extent that the action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulation. I understand that I may select the information from the list below to be released by placing a check mark or an "x" in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information.

I hereby authorize and request the above named to release the following:

- ☐ The complete medical history
- ☐ Diagnostic Tests: X-ray/ MRI / CT-SCAN / EMG- NCS, ETC.
- ☐ Doctors last notes
- ☐ Records of treatment during the period of _____ to _____
- ☐ Labs only
- ☐ Other: _____

Please fax records to:

407-265-2872

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature or Legal Representative Printed Name and Signature Date

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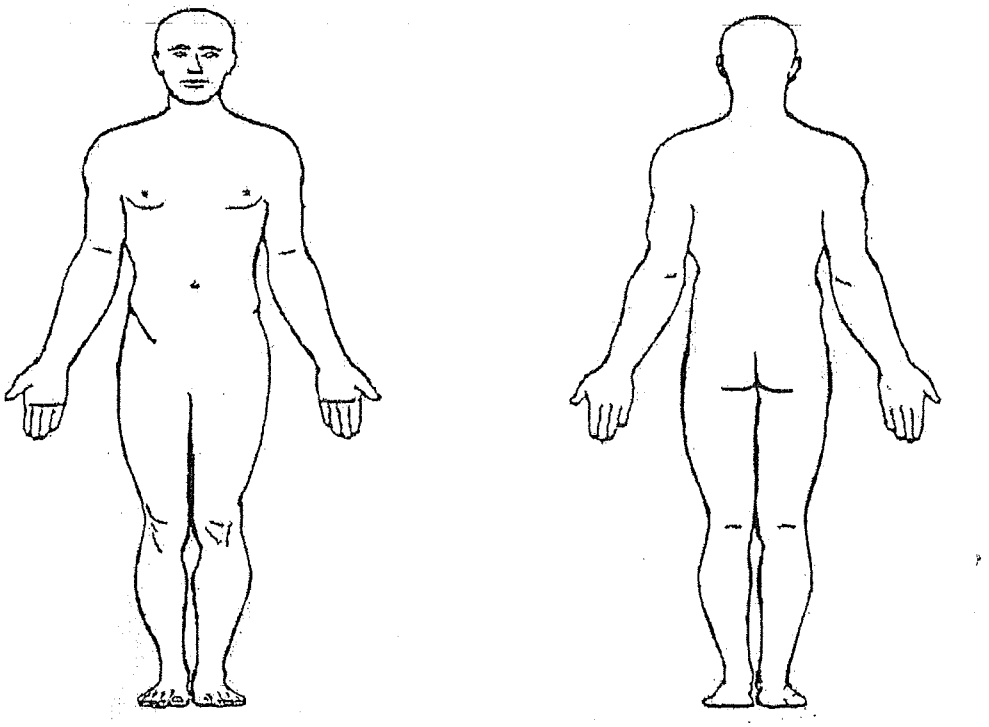
Pain Diagram

Name _____ Date _____

Mark the drawings below **where** you feel pain.

Please indicate ***which*** sensations you feel by referring to the key below
Burning XXXX Pins & Needles 0000 Numbness ==== Aching ++++ Stabbing ////



Consent for Treatment

Our office focuses on active rehabilitation programs to control or minimize your pain with the goal of maximizing your function. It is generally accepted that multidisciplinary treatment of chronic pain leads to best outcomes. Your compliance with this multidisciplinary approach (physical therapy, psychological interventions, consultations, medications) is necessary. Our goal is to minimize or taper off the use of medications as you recover. **Any unethical or aberrant behavior diversion, (selling medications to others, "doctor shopping', taking illicit substances, sharing medications, not taking medications as prescribed, etc.) will be grounds to be discharged from our care.**

The undersigned hereby **consents** to the provision of examination/evaluation, treatment, therapies, medical and laboratory procedures, and drugs and supplies by the healthcare providers of Pedro T. Oliveros Jr., MD, and, acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

I have read, understood and agreed to the above.

_____ _____
Patient Signature or Legal Representative Printed Name and Signature Date

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PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Occupation: _____ Marital Status: ☐ Married ☐ Single/Divorced ☐ Widowed

Do you currently have a medical marijuana card from any other state? ☐ Yes, State: _____ ☐ No

Are you currently on Federal probation or Federal parole? ☐ Yes ☐ No Are you a Florida resident? ☐ Yes ☐ No

Chief complaint (main reason for which you are seeking treatment): _____

Describe your symptoms: _____

_____

Please check if you have history of any of the following conditions:

☐ Chronic nonmalignant pain	☐ Epilepsy/Seizures	☐ Cancer: _____
☐ HIV / AIDS	☐ Crohn's disease	☐ PTSD
☐ Glaucoma	☐ Parkinson's disease	☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Multiple Sclerosis	☐ Schizophrenia	☐ Addiction / Alcoholism

Please check any personal history of:

☐ Ulcers ☐ Anemia ☐ Reflux ☐ Clots ☐ Infections ☐ Diabetes ☐ Depression/anxiety
☐ Heart disease ☐ High blood pressure ☐ Heart disease ☐ Lung disease ☐ Liver disease ☐ Thyroid disease
☐ Other: _____

List any pertinent **family** history: _____

List any prior **surgeries**: _____

Do you smoke? ☐ Yes ☐ No Do you frequently drink alcohol? ☐ Yes ☐ No Do you use illicit drugs? ☐ Yes ☐ No

FEMALES ONLY: Are you currently pregnant? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

List current **medications**: _____

_____

_____

List any **allergies** to any medication(s): _____

Patient's Release of Liability

In using cannabis therapeutically, I accept full responsibility in assuming the risks and side effects related to its use. I agree that the attending physician and his/her principals, agents, and employees, shall not be held responsibility for any harm resulting to me and/or other individuals as a result of my medicinal use of cannabis. I understand that I will not drive while taking high THC cannabis. I understand that the Federal Government's classifies marijuana as a schedule I controlled substance. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of medical cannabis. I understand that no fees associated with care or obtaining medical cannabis can be applied to any insurance plan, according to Florida State law. All fees will be paid by me or my legal representative.

Patient Signature_____ **Date:** _____**Physician's Initials**____