

Appt. Time: _____ Date: _____ NEW RENEWAL NO MEDICAL RECORDS

Cost of Service: \$ _____ Service : \$ 99 \$135 \$185 \$210 \$220 \$245

PAID WITH: CASH CHECK CREDIT CARD Location: GRAND RAPIDS



SOHAI LTD
1505 Lake Dr. SE
Grand Rapids, MI 49506
855-697-6424

OFFICE NOTES: _____

CK IN _____ QUE CK _____ CK OUT _____

PATIENT GENERAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Apt #: _____ Date Of Birth: _____

City: _____ State: _____ Zip: _____ Sex: Male Female

Height: ___ft ___in Phone No.: _____ E-Mail: _____

Would you like to be added to our mailing list? Yes No

Emergency Contact: Name: _____ Phone No. _____

How did you hear about SOHAI. (please be specific). Google Search Get Legal America Marijuana Doctors.com
Leafly Weed Maps MMMP Report

Other: _____

PATIENT PRE-QUALIFICATION FOR THE MICHIGAN MEDICAL MARIJUANA PROGRAM

Is this your first visit to our clinic? Yes No If No, when? _____

Is this a NEW or RECERTIFICATION with MMMP? NEW RECERTIFICATION

The following conditions are qualifications for the MMMP program.
Please select the condition(s) you are seeking qualifications for the MMMP program.

- | | | |
|---|--|---|
| Amyotrophic Lateral Sclerosis: <input type="checkbox"/> | Glaucoma: <input type="checkbox"/> | Severe Nausea: <input type="checkbox"/> |
| Agitation of Alzheimer's: <input type="checkbox"/> | HIV/AIDS: <input type="checkbox"/> | Seizures: <input type="checkbox"/> |
| Arthritis: <input type="checkbox"/> | Multiple Sclerosis: <input type="checkbox"/> | Chronic Pain: <input type="checkbox"/> |
| Cachexia Disease: <input type="checkbox"/> | Nail Patella: <input type="checkbox"/> | Severe Pain: <input type="checkbox"/> |
| Crohn's Disease: <input type="checkbox"/> | Muscle spasms: <input type="checkbox"/> | Hepatitis C <input type="checkbox"/> |
| Cancer: <input type="checkbox"/> | Persistent Migraines: <input type="checkbox"/> | Post-Traumatic Stress Disorder <input type="checkbox"/> |

Other _____

On a scale of 1 - 10, how would you rate the severity of your condition (when at it's worse): _____

How long have you been suffering from this condition? _____

Has a doctor diagnosed you with the condition? Yes No

What is the name and address (city is fine) of the doctor(s) that you have seen for the condition(s)?

1. _____

2. _____

3. _____

PATIENT HISTORY OF CONDITION

Do you smoke Marijuana? Yes No Has Marijuana helped with your conditions(s)? Yes No

Explain Marijuana use and results: _____

Do you currently take prescription medication? Yes No

Please list ALL medications that you are currently taking, including strength and dosage.

If you have a list already prepared, leave this area blank and submit your list to the doctor.

Are you allergic to any medications?

Do You Smoke Tobacco? Yes No

Have you ever Smoked Tobacco? Yes No If Yes, Date: _____

I hereby certify, that all the information that I have provided on this form, is true and accurate.

Signature

Date

PATIENT WAIVER AND CONSENT FORM

I _____, hereby authorize, your Doctor to evaluate me for my medical condition.
(Print your name here)

I understand that your Doctor will be conducting the evaluation in person and any information shared is private and confidential.

I understand that it is my responsibility to provide medical records, if available and also provide accurate information regarding my medical condition.

Providing information that is untruthful or inaccurate, is solely my responsibility, SOHAI LTD and their Doctor, bear no liability regarding misinformation.

Your Signature

Today's Date

LIABILITY WAIVER AND RELEASE

I _____, do hereby acknowledge that SOHAI LTD and their Doctor are not liable, nor can be held accountable;
(Print your name here)

for any action relating to or arising from my use or possession of marijuana. I further acknowledge that SOHAI LTD and their Doctor, are not affiliated with the State of Michigan, Licensing And Regulatory Agency (LARA)

or the Michigan Medical Marihuana Program (MMMP) and that SOHAI LTD and their Doctor cannot be held liable, should the LARA or the MMMP deny my application, for any reason whatsoever.

I further accept, understand and acknowledge that:

1. SOHAI LTD is not a dispensary and cannot provide me with Medical Marijuana or any other medication.
2. That the Doctor's recommendation of Medical Marijuana is not a guarantee that it will cure or aid in the treatment of the condition it is intended for, and that I am solely responsible for taking Medical Marijuana.
3. I acknowledge that your Doctor has explained to me the purpose of Medical Marijuana, its benefits and side-effects. I have been given the opportunity to ask any questions or raise any concerns regarding the use of Medical Marijuana or its possible side-effects and that all my questions have been answered to my satisfaction.

Your Signature

Today's Date

Doctor's Comments: _____ _____ _____ _____ _____ _____ _____ _____
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Society of Healing Arts Institute
1505 Lake Dr. SE
Grand Rapids, MI 49506
616-719-0441

I, _____,

could not provide medical records today outside of past certifications.

I commit to doing any diagnostics that the doctor orders today and to return in 3 months for a check up with the doctor. (\$36)

I understand that if I do not follow through that the doctor may call the state and revoke my card.

X _____

Dr. Richard Piazza D.O.
Dr. Victor Jimenez M.D.
Dr. Gavin Awerbauch M.D.
Dr. Michael Tomaszczk D.O.



1505 Lake Drive SE
Grand Rapids, MI 49506
616-719-0441

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____ Previous Name(s): _____

I request and authorize _____ at (_____) - _____ - _____
(My Doctor's Name/Hospital/ Facility) (my doctor's telephone/fax #)

to release healthcare information of the patient named above to:

Society of Healing Arts Institute
Holistic Healthcare Center
1505 Lake Drive
Grand Rapids, MI 49506

Main Office: 616-719-0441
Fax: 844-697-6424

Records Requested: _____
(the reason you're seeing our doctor)

The purpose of this request and the rules thereof are pursuant to: MMA333.26423(a)(1)
and will expire 90 days from the date, authorized by signature, listed below.

Dates of Treatment: _____

YES NO I authorize the release of my STD results, HIV/AIDS testing, whether negative/positive, to the facility listed above. I understand that the facility listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

YES NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the facility listed above.

Patient's Signature: _____ Date: _____

The patient reserves the right to revoke this authorization at anytime thereafter, by submitting a written request, stating the reason for the revocation, as long as the patient submits the request in a timely manner, before the request has been carried out and the requested medical records have not been released.



Patient Attestation & Pre-Exam Form



MMA333.26423(a)(1)(2)(3) EFFECTIVE APRIL 1, 2013 Act No. 512

Sec. 3. As used in this act:

(a) "Bona fide physician-patient relationship" means a treatment or counseling relationship between a physician and patient in which all of the following are present:

- (1) The physician has reviewed the patient's relevant medical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of the patient.
- (2) The physician has created and maintained records of the patient's condition in accord with medically accepted standards.
- (3) The physician has a reasonable expectation that he or she will provide follow-up care to the patient to monitor the efficacy of the use of medical marihuana as a treatment of the patient's debilitating medical condition.

First Name: _____ Last Name: _____ Date Of Birth: _____

DEFINITION OF PAIN

Acute Pain: Pain associated with a illness, condition or injury, that is expected as a result of the condition.

Chronic Pain: Pain that last longer than expected due to an illness, condition or injury.

Persistent Pain: Pain that continues, even after the illness, condition or injury has healed. Usually due to scaring or inflammation, that is the result of the illness, condition or injury.

BY SIGNING THIS FORM, I AM AGREEING TO THE FOLLOWING:

1. I agree to return to this office in 3 months for a follow up visit to see the doctor.
2. I agree to will pay \$35 for the office visit.
3. I acknowledge that if I do not show up for my follow up visit, the doctor reserves the right to contact the State of Michigan and have you removed from the program.

NOTE: THIS WILL NOT DELAY YOU RECEIVING YOUR CARD, WHICH SHOULD ARRIVE WITHIN 60 DAYS.

Patient Attestation

Please state "in your own words", your medical issues and using the diagram, circle the problem areas.

Describe the results you've experienced from the medication(s) you've taken.

