Northeastern Rehabilitation
ASSOCIATES, P.C.

Thank you for choosing Northeastern Rehabilitation Associates

-www.nerehab.com-

To ensure *we are providing quality care, we need information from you and need to provide you with information about our practice policies. Our* ***New Patient Brochure*** *is enclosed and it outlines our services and practice policies. Please review prior to your visit.*

Please complete the attached New Patient Packet in its entirely prior to arriving for your appointment. ***You MUST bring any and all medical records that pertain to the diagnosis you are asking NERA providers to evaluate you for.*** *This information is important for your physician to review with you during your initial visit.* ***If you do not have medical records or the attached packet completed, your appointment will be rescheduled.***

Many of our patients experience acute and chronic pain. NERA Physicians will work with you to create an effective treatment plan, tailored just for you. Goals of a treatment plan often include reducing pain, maximizing your ability to perform functions of daily living and to help improve your quality of life. Patient Health Questionnaires are tools used to assist in creating your treatment plan. Please complete the enclosed, ***SOAPP-14*** *questionnaire and bring with you to your first visit. You may be asked to update this information annually or more often as your treatment plan changes over time.*

To provide you with secure electronic access to our physicians and staff, Northeastern Rehabilitation Associates utilizes a ***Patient Portal****. Instructions for access are included in this packet. You can request appointments, update your medical history, medications, allergies, and send a note to your provider. Your provider may send forms for you to complete as part of your treatment plan via the Portal as well.*

We encourage you to sign up for the Patient Portal before your first visit.

Northeastern Rehabilitation ASSOCIATES, P.C.

IMPORTANT

It is very important that the attached Medical Record Authorization form be completed and returned to us ***before your visit.***

PLEASE DO NOT SEND THE ENTIRE PACKET BACK – JUST THE AUTHORIZATION FORM. BRING THE COMPLETED PACKET WITH YOU ON THE DAY OF YOUR APPOINTMENT.

Many medical offices will not forward your medical office notes or imaging to us without a signed authorization. If your NERA provider does not have your prior medical records at the time of your initial visit he/she will not be able to fully implement a treatment plan for you.

You may return this form to us by any of the following methods:

For all office locations:
Scan and email to MR@nerehab.com
Note: This address is only for Medical Record Authorization forms.
No other communication will be addressed.

- or -

Scranton Office:
Attention Medical Records
Drop off/Mail to:
5 Morgan Hwy- Suite 4- Scranton PA, 18508
Fax: 570-558-6361

Wilkes-Barre Office:
Attention Medical Records
Drop off/Mail to:
150 Mundy Street, Mac IV, Wilke-Barre, PA 18702
Fax: 570-270-6279

Bethlehem Office:
Attention Medical Records
Drop off/Mail to:
3400 Bath Pike, Bethlehem, PA 18017
Fax: 484-895-3187

Northeastern Rehabilitation ASSOCIATES, P.C.

LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM
(Please print all information. Form must be signed and dated each year).

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information:

☐ Northeastern Rehabilitation Associates, PC, 5 Morgan Highway, Suite 4 Scranton, PA 18508
☐ Northeastern Rehabilitation Associates, PC, 150 Mundy Street, MAC IV, Wilkes-Barre, PA 18702
☐ Northeastern Rehabilitation Associates, PC, 3400 Bath Pike, 4th Floor, Suite 400, Bethlehem, PA 18017

- Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ office notes
☐ lab results, pathology reports
☐ x-rays;
☐ financial history report *(previous 3 years only)*
☐ nursing home, home health, hospice, and other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify):

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.

Patient Information Sheet *(Please Print)*

Patient Name: _____
Last First Middle I

Date of Birth: _____ / _____ / _____ **Soc. Sec. # :** _____ / _____ / _____ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language**:_____

Home #: _____ **Cell #:** _____ **Work #:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact_____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ **Primary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

■ **Secondary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

PLEASE COMPLETE THIS SECTION IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT

Patient Name: _____

■ **Work Related Injuries**

Date of Injury: _____ / _____ / _____ **Claim #:** _____

Employer: _____ **County located in:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

Address where Injury Occurred- if different than address above:

City: _____ **State:** _____ **Zip:** _____

Job Title: _____ **Usual Job Duties:** _____

■ **Auto Accident**

Date of Injury: _____ / _____ / _____ **Claim #:** _____

State where Injury Occurred: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

■ **Attorney Information - if Applicable**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

PATIENT PAIN HISTORY:

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

1. Which is your dominant hand? ☐ Left ☐ Right ☐ Ambidextrous
2. What is your main complaint?_____
   _____
   _____
3. Is this the result of a Work Injury? ☐ No ☐ Yes **If yes**, date of injury: _____/_____/_____
   Describe this incident: _____
   _____
   _____
4. Is this the result of a Motor Vehicle Accident? ☐No ☐ Yes **If yes**, date of accident: _____/____/_____
   Describe this incident: ☐ Head-On ☐ Rear-Ended ☐ T-Boned ☐ Other_____
   _____

☐ Driver ☐ Passenger Front Seat ☐ Passenger Back Seat	☐ Loss of consciousness ☐ Airbags deployed ☐ Seatbelt	☐ Ambulance: ☐ C-Collar ☐ Backboard Name of ER: _____

5. If you answered NO to questions 3 and 4, please describe when and how your illness or injury occurred:
   _____
   _____
6. Have you had anything similar before? ☐ No ☐ Yes **If yes,** please explain:
   _____
   _____
7. Prior to this episode, were you completely symptom free? ☐Yes ☐ No **If no**, please explain:
   _____
   _____
8. What doctors have you seen for this problem?_____
   _____
9. TESTING
   Which of the following tests have been done for your condition?
   ☐ X-ray* Date:_____/_____/_____ Facility _____
   ☐ MRI* Date:_____/_____/_____ Facility _____
   ☐ Cat Scan* Date:_____/_____/_____ Facility _____
   ☐ Bone Scan* Date:_____/_____/_____ Facility _____
   ☐ EMG Date:_____/_____/_____ Facility _____
   ☐ Other: _____ Date:____/_____/_____ Facility _____

*** Please bring any/all X-rays, MRIs, and Medical Records that may pertain to your current problem/injury.**

Patient Name: _____

10. Please review the pain scale below. Indicate by answering **0-10** which best describes your pain level:
a. Current pain level:_____ **b.** Past 30 days, pain at its best:_____ **c**. Past 30 days, pain at its worst: _____

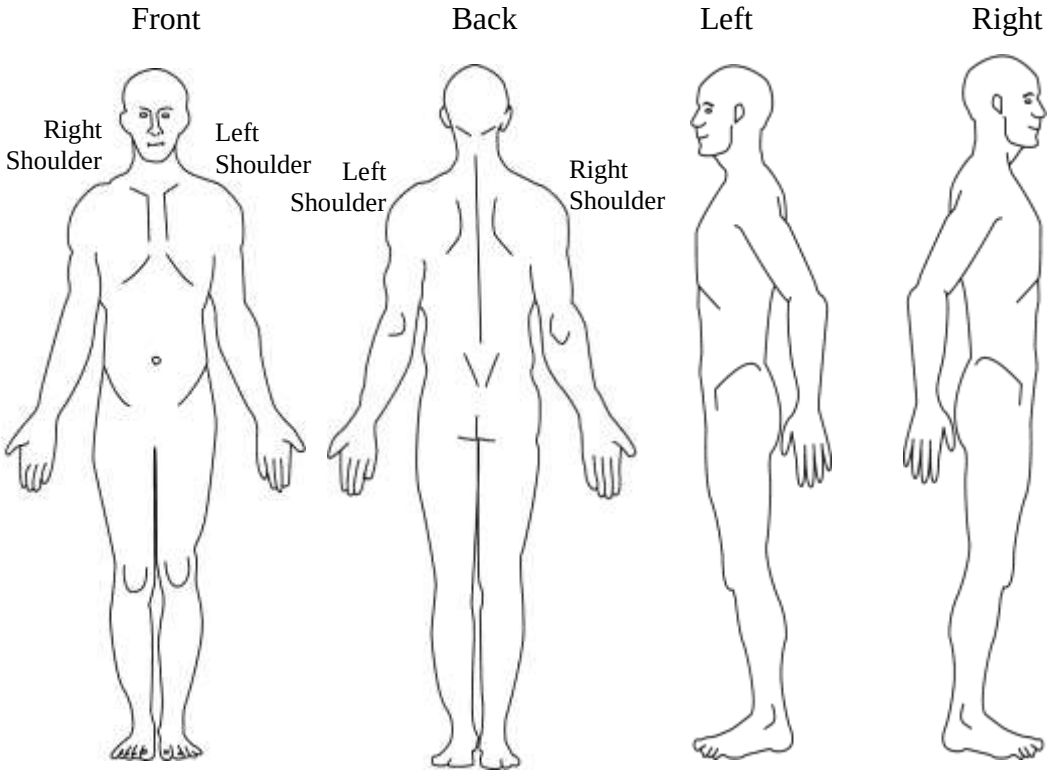
0	**No Pain**	I have no pain
1	**Minimal**	My pain is hardly noticeable
2	**Mild**	I have a low level of pain, I am aware of my pain only when I pay attention to it
3	**Uncomfortable**	My pain bothers me but I can ignore it most of the time
4	**Moderate**	I am constantly aware of my pain but I can continue with most of my activities
5	**Distracting**	I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.
6	**Distressing**	I think about my pain all of the time. I give up many activities because of my pain.
7	**Unmanageable**	I am in pain all the time. It keeps me from doing most activities
8	**Intense**	My pain is so severe that it is hard to think of anything else. Talking and listening are difficult.
9	**Severe**	My pain is all that I can think about. I can barely talk or move because of the pain.
10	**Unable to Move**	I am in bed and can't move due to my pain. I need someone to take me to the emergency room to get help for my pain.

11. How frequent is your pain? ☐ Constant ☐Intermittent Explain_____
12. How long does your pain last? ☐ Less than 1 hour ☐ Less than 1 day ☐All day ☐All night
13. Is your pain getting: ☐ Better ☐ Worse ☐ Not changing

	Worsens Pain	**Relieves Pain**	**No Effect on Pain**		**Worsens Pain**	**Relieves Pain**	**No Effect on Pain**
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/Sneezing			
Bending forward				Lying on your side			
Bending backward				Lying on your back			
Bending to the side				Lying on your stomach			

USE THE FOLLOWING SYMBOLS TO INDICATE ON THE DRAWING EXACTLY WHERE YOUR PAIN IS <u>AT THE PRESENT TIME</u>.

Burning (X) Numbness (O) Pins/Needles (=) Stabbing (/) Ache (^) Throb (V **)**



Patient Name: _____

1. Have you had any Physical Therapy in the past 2 years? ☐ No ☐ Yes
   If yes, please indicate the following:

   a. Body Part Treated: _____ Facility:_____
   When (Month/Year): _____ How Long: _____
   b. Body Part Treated: _____ Facility:_____
   When (Month/Year): _____ How Long: _____

2. Please check next to any other treatments you have had for your **present** injury:

   ☐ Ice/Heat: Helpful? Yes ☐ No ☐
   ☐ Anti-inflammatory Medications (NSAIDs) including over the counter Advil, Aleve, etc.
   When? _____ / How Long?_____ Helpful? Yes ☐ No ☐

   ☐ TENS/ E Stim: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Traction: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Exercises: Helpful? Yes ☐ No ☐
   ☐ Acupuncture: Helpful? Yes ☐ No ☐
   ☐ Massage: Helpful? Yes ☐ No ☐
   ☐ Chiropractic: Helpful? Yes ☐ No ☐
   ☐ Injections: Helpful? Yes ☐ No ☐ What type of injection?_____
   When was your last injection? _____
   ☐ Bracing: Helpful? Yes ☐ No ☐
   ☐ Psychological Treatment: Helpful? Yes ☐ No ☐

3. With respect to your pain, how are you feeling now compared to before you received treatment?

   ☐ Very Much Worse ☐ Much Worse ☐ Minimally Worse ☐ No Change
   ☐ Minimally Improved ☐ Much Improved ☐ Very Improved

PAST MEDICAL HISTORY:

Do you or have you had any problems with the following: (Check all that apply)

☐ Alcohol Abuse	☐ Cholesterol	☐ Hepatitis	☐ Stroke/ TIA
☐ Arthritis (Osteoarthritis)	☐ Diabetes	☐ HIV/AIDS	☐ Thyroid
☐ Arthritis (Rheumatoid)	☐ Fibromyalgia	☐ Hypertension	☐ Anxiety
☐ Asthma	☐ GERD (Reflux)	☐ Kidney Disease	☐ Depression
☐ Cancer	☐ Heart Disease	☐ Liver Disease	
Type: _____	☐ Drug Abuse ☐ Prescription drugs ☐ Street drugs		

☐ Other: _____

☐ Past Work Injury – Date: _____ ☐ Past Motor Vehicle Accident – Date: _____

PLEASE LIST SURGERIES YOU HAVE HAD: **DATE:**

_____ _____
_____ _____
_____ _____

Patient Name: _____

FAMILY HISTORY: Please check any diseases/disorders that run in your family. **Do not include yourself**.

	Relative		**Relative**		**Relative**
☐ Heart disease	_____	☐ Arthritis	_____	☐ Hypertension	_____
☐ Alcohol Abuse	_____	☐ Diabetes	_____	☐ Drug Abuse	_____
☐ Cancer	_____	☐ Other	_____		

SOCIAL HISTORY:

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_____
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_____ Per week?_____
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? _____

EMPLOYMENT STATUS:

1. Job Title/Occupation: _____
2. Briefly describe your job duties: _____
3. Are you currently under work restrictions ☐ No ☐ Yes **If Yes,** what are your restrictions?
   _____
4. Please check current work status:
   ☐ Working Full Time: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Working Part Time: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Working Light Duty: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Off Duty Due to Injury: Date last worked: _____
   ☐ Retired/Not Working

ACTIVITIES OF DAILY LIVING: Please check the level you are presently able to complete the following activities:

	Independent	**Need some Assistance**	**Unable**		**Independent**	**Need some Assistance**	**Unable**
Walk	☐	☐	☐	Feed yourself	☐	☐	☐
Dress	☐	☐	☐	Clean your house	☐	☐	☐
Bathe	☐	☐	☐	Care for your family	☐	☐	☐
Drive	☐	☐	☐				

1. Please list up to four things in your life that you can't do or have difficulty with because of your pain and which most dearly you want restored? These should be simple, realistic daily life improvements that other people can see most of the time.
   _____ _____
   _____ _____
2. Are there other limitations due to current condition?_____
3. At one time, how long can you: Sit _____ Stand_____ Walk_____
4. Do you use any of the following? ☐ Straight cane ☐ Quad cane ☐ Walker ☐ Wheelchair
   Prior to your injury/illness was your ability to do things at all limited? ☐No ☐Yes
   If yes, please explain: _____
5. Are there stairs to enter/or in your home? ☐ No ☐ Yes How many? ____ Is there a rail? ☐ Yes ☐ No

Patient Name:_____

Review of Systems

Do you have problems with any of the following? Please check all that apply.

General
☐Fatigue
☐Weakness
☐Trouble sleeping

Skin
☐Rashes
☐Dryness
☐Color changes
☐Hair/nail changes

Head
☐Headache
☐Head Injury

Eyes/Ears/Nose/Throat
☐Blurry or double vision
☐Eye pain
☐Blindness
☐Ear pain
☐Ringing in ears
☐Deafness
☐Nose bleeds
☐Dry mouth
☐Sore throat/hoarseness
☐Non-healing sores

Neck
☐Stiffness
☐Swollen glands
☐Pain

Cardiac
☐Palpitations
☐Chest discomfort at rest
☐Chest discomfort with activity

Respiratory
☐Wheezing
☐Shortness of breath with normal activity
☐Shortness of breath with exertion
☐Cough- wet, dry or productive
☐Coughing up blood

Circulation
☐Discoloration of feet/legs
☐Sores/ulcers on feet/legs
☐Swelling of ankles/legs
☐Calf pain with walking
☐Leg Cramps
☐Varicose veins

Gastrointestinal
☐Difficulty swallowing
☐Heartburn
☐Unexplained nausea/vomiting
☐Change in bowel habits
☐Constipation
☐Diarrhea
☐Blood in stool
☐Loss of bowel control
☐Abdominal pain

Genitourinary
☐Frequent urination
☐Painful urination
☐Loss of bladder control

Musculoskeletal
☐Muscle or joint pain
☐Stiffness
☐Back pain
☐Redness of joints
☐Swelling of joints
☐Trauma

Nervous System
☐Dizziness
☐Fainting
☐Seizures
☐Numbness/Tingling

Metabolism/Endocrine
☐Heat or cold intolerance
☐Excessive sweating
☐Increased thirst
☐Change in appetite
☐Recent unexplained weight changes

Hematology
☐Unexplained fevers
☐Ease of bruising
☐Ease of bleeding

Psychiatric
☐Nervousness
☐Memory loss
☐Stress
☐Bipolar Disorder
☐Other psychological diagnosis _____

Women Only
☐Currently pregnant
☐Breastfeeding
☐Date of last menstrual period
____/____/_____

Reviewed By:

_____

Date: _____/_____/_____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list **ALL** medications taken on a daily basis, including **vitamins, herbals and over-the-counter medications**. Please list all **medication allergies.**
Please list pharmacy name and telephone number.

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed**:** _____

MEDICATION ALLERGIES:

_____

_____

Pharmacy Name _____ **Phone Number**_____

Northeastern Rehabilitation ASSOCIATES, P.C.

Screener and Opioid Assessment for Patients with Pain- SOAPP V1- 14Q

As part of your treatment plan with your Northeastern Rehabilitation Associates (NERA) physician, you may receive a prescription for a controlled substance medication. In addition to medication agreements and random drug screen protocols, NERA requires a medication screening form to be completed by all patients receiving these medications. **Your health insurance may also require a pre authorization of this medication before it can be filled by your pharmacy. The pre authorization process also requires the completion of this form.**

Name: _____ Date of Birth: _____ Date: _____

Please Print

The following are some questions given to all patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Please answer the questions below using the following scale: (Circle answer)

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	**0 1 2 3 4**
2.	How often do you smoke a cigarette within an hour after you wake up?	**0 1 2 3 4**
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	**0 1 2 3 4**
4.	How often have any of your close friends suggested that you have a drug or alcohol problem?	**0 1 2 3 4**
5.	How often is there tension in the home?	**0 1 2 3 4**
6.	How often have you attended an AA or NA meeting?	**0 1 2 3 4**
7.	How often have you taken medication other than the way it was prescribed?	**0 1 2 3 4**
8.	How often have you been treated for an alcohol or drug problem?	**0 1 2 3 4**
9.	How often have your medications been lost or stolen?	**0 1 2 3 4**
10.	How often have others expressed concern over your use of medication?	**0 1 2 3 4**
11.	How often have you felt a craving for medication?	**0 1 2 3 4**
12.	How often have you been asked to give a urine screen for substance abuse?	**0 1 2 3 4**
13.	How often have you used illegal drugs (example marijuana, cocaine, etc) in the past five years?	**0 1 2 3 4**
14.	How often, in your lifetime, have you had legal problems or been arrested?	**0 1 2 3 4**

Please include any additional information you wish about the above answers. Thank you.

NERA Medical Marijuana Agreement

Your health and safety are very important to us. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship. Because we take our responsibilities to authorize and supervise the medical use of marijuana very seriously, we ask you to read, understand, and sign this form.
This is an agreement between you and your NERA Physician concerning the use of Medical Marijuana for the treatment of _____.

Please read each statement and sign below. If you have any questions regarding this information or practice policy regarding the prescribing of Medical Marijuana, please request clarification from your NERA physician. If you would like a copy of this Agreement for your records, please ask the staff to provide you with a copy during your visit.

1. I request treatment of my condition noted above, with Medical Marijuana. I understand the main goal is to improve my ability to function /work and to reduce pain. I have been treated with other therapies for my condition, which have not provided adequate relief of my symptoms. I understand that it may not be possible to completely eliminate all of my pain. I am aware that my NERA physician may discontinue the prescribing of medical marijuana if he/she assess that the medical or mental health risks or side effects are too high.

2. I understand that if I am currently taking any controlled substances for my pain, my NERA physician may taper and wean me off these substances prior to certifying me for Medical Marijuana.

3. I agree to comply with the treatment plan as prescribed by my NERA physician. In addition to utilizing Medical Marijuana; other medical treatments, following better health habits such as exercise, weight control and avoiding the use of nicotine and alcohol, may be part of my treatment plan.

4. I understand that marijuana is a strong drug and that there is insufficient scientific evidence to confirm its use for clinical purposes. There is also insufficient evidence on the clinical risks and benefits of this drug, including the proper dosage to be used for various medical conditions and symptoms, and the potential interactions between this drug and other medications. As such, I understand my NERA physician may not be knowledgeable about all the risks associated with marijuana use.

5. I understand my Medical Marijuana regimen may be continued for a definitive time period as determined by my NERA physician. According to PA Law, Medical Marijuana must be recertified on an annual basis. My treatment plan will be reviewed periodically. If there is no significant evidence of improvement or progress being made to improve my functioning or quality of life, the regimen may be tapered or possibly discontinued and my care referred back to my primary care physician.

6. I understand I must inform my NERA provider of **all** medications I am taking, including over-the-counter, herbals, and vitamins, as Medical Marijuana can interact with other medications.

7. I understand I must notify my NERA physician if I have a history of alcohol and/or drug misuse/addiction, as treatment with Medical Marijuana may increase the possibility of relapse. I understand there is a risk of becoming addicted to marijuana. This means I might become psychologically dependent on marijuana, using it to alter my mood or get high. I may be unable to control my use of it. If this occurs, my medical marijuana certification will be discontinued and I will be referred to a drug treatment program for help with this problem.

8. I understand that there are potential side effects and interactions involved with taking any medication, including the risk of addiction. Possible adverse effects of Medical Marijuana include but are not limited to: facial flushing, red eyes, dry mouth, drowsiness, sedation, dizziness, fainting, clumsiness, confusion, fuzzy thinking, impaired attention, impaired concentration, impaired short term memory, agitation, anxiety, paranoia, delusions, hallucinations, amnesia, fast or slow heartbeat. I may develop a tolerance, and become physically dependent on the medication. I understand some side effects of medical marijuana are made worse when used with other medication; for example drowsiness, sedation and dizziness are worse when marijuana are used with sleeping medication, tranquilizers, pain medications, antihistamines and seizure medications to name a few. I will notify my NERA physician if I experience any adverse effects such as experiences of altered mental status or possible medical side effects as noted above. I understand that when I first start taking marijuana, I may experience the adverse mood reactions noted above. With long term use of marijuana, the effects on attention, concentration and short term memory may worsen and can persist after I stop using marijuana.

9. I agree not to drink alcohol or take other mood altering drugs (tranquilizers, sleeping pills, other mood stabilizers) unless they are prescribed to me by my NERA physician. I understand that using marijuana with other drugs may lead to an overdose.

10. I agree to take my Medical Marijuana only and **exactly** as prescribed by the licensed PA Dispensary. I will not change the amount or frequency of my marijuana use without first discussing it with my NERA physician.

11. I understand running out of my Medical Marijuana early, requesting early refills, escalating doses without permission and losing my medical marijuana, may be signs of misuse and may be reasons for my NERA physician to discontinue certifying medical marijuana to me.

12. I agree to tell any other physician who might treat me that I take marijuana for medical reasons.

13. I agree to tell my NERA physician if I receive any new medications prescribed to me by any other physician and if any doses of my current medications are changed by another physician.

14. As per PA legislation, I agree to purchase my marijuana only from a Licensed Dispensary. I am aware that possession of marijuana from other sources is illegal.

15. (Female patients only) I understand that if I plan to get pregnant or believe that I have become pregnant while taking Medical Marijuana, I will immediately notify my obstetric and NERA physician. I understand that marijuana use is not advisable during pregnancy and breastfeeding. I understand that if I am pregnant or become pregnant while taking marijuana, my child may acquire behavioral and attention problems as a result of prenatal exposure to marijuana, as well as other unknown complications. It is believed there is also an increased risk of sudden infant death syndrome in babies born to mothers using marijuana during pregnancy.

16. I understand that I must exercise extreme caution when taking Medical Marijuana while driving or operating heavy machinery. I agree to avoid driving a vehicle (including all-terrain vehicles, snowmobiles, boats, etc.) or operating heavy machinery for at least 4 hours after the use of marijuana or longer there is any question of my ability to safely perform these activities that could put my life or someone else's life in jeopardy.

17. I understand that NERA does not replace lost, damaged or stolen medications or those destroyed by fire, flood, etc. The safekeeping of my medication and prescriptions is my responsibility. I will not distribute, share, sell, exchange or otherwise permit others to have access to my Medical Marijuana for any reason. I realize this is an illegal act. I agree to keep my marijuana in a safe and secure place, away from children. I will report any stolen marijuana to the police and my NERA physician immediately.

18. I accept full responsibility for any and all risks associated with the use of marijuana, including theft, altered mental status, and side effects to the medication. I agree that my NERA physician and my dispensary may work with the police to look into any alleged misuse or sale of my marijuana.

19. I agree that I will not seek or accept any pain medications or Medical Marijuana from any other source except my NERA physician. This includes prescriptions for pain medications from other physicians, medication borrowed or accepted from family or friends and any illicit or street drugs. If I am in an emergent situation, have surgery, a dental procedure, etc. and am given a controlled substance by another physician, I will notify that physician that I am taking Medical Marijuana and will notify my NERA physician as soon as possible. I consent to the disclosure of all personal health information related to this matter.

20. I am aware that co-ingestion of substances, especially sedating substances, may cause harm and possibly even death. I agree that I will not use any illegal substance, (cocaine, heroin, other forms of marijuana, etc.) or controlled substances (narcotics, stimulants, anxiety pills) while being treated with Medical Marijuana. I understand that using illegal substances will result in a change to my treatment plan, including the safe discontinuation of Medical Marijuana when applicable and may result in the termination of my NERA doctor/patient relationship.

21. I agree to keep all scheduled appointments. I understand I may need to be seen by my NERA provider at least every three months. I agree to attend all requested follow-up visits and I understand that failure to do so could result in the discontinuation of my marijuana treatment. I agree to attend all appointments that my doctor makes for me for tests, assessments and treatment with other healthcare workers, such as pharmacists, other doctors, physiotherapists, psychologists, addiction counsellors, etc. I consent to open communication between my doctor and any other healthcare professional involved in my healthcare.

22. I understand that if I am 15 minutes late for an appointment time, I will be rescheduled for another appointment on another date and time. I understand scheduled appointments are required for all office visits and that NERA physicians do not see “walk-in” patients.

23. I understand that my NERA Provider is required to check my prescription history via the state database, *PA Aware*, while taking Medical Marijuana. I give permission to my NERA physician to verify that I am not seeing other physicians for prescriptions of marijuana, opioids or other mind altering medications and to verify that I am only going to one licensed producer/distributor or one designated producer.

24. I understand that I will undergo random urine, saliva or blood drug screens as long as my treatment plan utilizes Medical Marijuana. I accept responsibility for the cost of these screens in the event my healthcare coverage will not cover the costs. If the results of these screens do not reflect medicine prescribed by my NERA physician, or if I test positive for illegal substances, I understand this may result in the discontinuation of my Medical Marijuana certification and I may be discharged from the practice immediately.

25. I understand that NERA cooperates fully with law enforcement agencies in regards to infractions involving medications. I am aware that any possible criminal activity related to my marijuana use may be investigated by legal authorities and criminal charges may be laid. During the course of an investigation, legal authorities have the right to access of my medical information with a warrant.

26. I understand that inappropriate, abusive behavior, or harassment of my NERA physician or any NERA staff member, will not be tolerated. If this occurs, my NERA physician may discontinue my medical marijuana certification. I may be asked to leave the office, and the police may be called. I will be discharged from the practice immediately.

27. I understand that NERA physicians may discontinue certification for Medical Marijuana and discharge me from the practice if any of the following occurs:

- I give, sell, or misuse my Medical Marijuana, including but not limited to: taking more medication than prescribed, running out of medication early,
- I fail to keep follow- up appointments,
- I attempt to obtain medical marijuana or controlled substances after office hours, on the weekend, on holidays, from any other physician, or any other source,
- I do not cooperate with requested Drug screens, or there is any discrepancy with results of said testing,
- Any aggressive behavior toward NERA staff or physicians,
- Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of my NERA physician.

28**. By signing this document I acknowledge that**:

- I have thoroughly read, understand and accept all the above statements.
- I have had the opportunity to ask any questions I have regarding medical marijuana and its use, in particular to my health condition. My concerns and questions have been addressed to my satisfaction by my physician.
- My NERA physicians may provide a copy of this agreement to my Medical Marijuana Dispensary, pharmacy, referring physician and all other physicians involved in my care.

This agreement is in effect for the duration of my treatment with Medical Marijuana.

Patient Signature _____ Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____
(Please Print)

Medical Marijuana Dispensary: _____ Phone# _____ / _____ / _____

Reviewed by Physician/Staff Signature _____ Date____/____/____