

Instructions:

If you need new copies of the forms, please feel free to download more from our website, www.M4-C.com. If you have difficulty downloading or printing pages, please contact us via email at support@M4-C.com or via telephone at (517)376-3229 for assistance.

DO NOT SEND ORIGINAL MEDICAL RECORDS

Send only copies M⁴-C may keep.

DO NOT SEND MORE THAN 20 PAGES

without prior permission from doctor.

1. Fill out and sign the “**Current Health Status Questionnaire & Current Healthcare Provider Information**” form.

At the bottom of the page, please provide the name and contact information of your primary care provider or clinic and/or the specialist whom you currently see for your qualifying condition(s).

2. Next, fill out and sign the “**Healthcare Agreement**” form.
3. Finally, fill out and sign the “**Authorization to Release Medical Records to M⁴-C**” form.

(Fill out 1 Release form *for each healthcare provider or specialist* you have seen from whom we should obtain medical records.) **We must be able to obtain records from a prior provider in order to verify the presence a pre-existing qualifying condition.**

IMPORTANT NOTE: EVEN IF YOU ALREADY HAVE WHAT YOU BELIEVE TO BE PERTINENT MEDICAL RECORDS, YOU MUST STILL DO #4.

We frequently need additional records.

4. Return the completed forms to M⁴-C:

Via Fax: (810)496-0073

Or

Via Email: Patient.Forms@M4-C.com

(Once your records have been emailed to M4-C, the records are always stored and transferred in a safe, secure, encrypted environment. As of this time, however, unless you have a secure, encrypted and/or passworded internet connection, this method is not considered safe from interception by third parties. **For speed and security, FAXING is recommended.**)

Or

Via United States Postal Service:

Mitchell A. Cohn, D.O.

P.O. Box 80977

Lansing, Michigan 48908

THAT’S IT! ... We’ll take it from there.

We will use the documents to obtain appropriate medical records, do a pre-visit review, and then contact you to set up an appointment, if appropriate.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

to

Mitchell A. Cohn, D.O.

General Practice With Emphasis on

Osteopathic Manipulative Medicine and Pain Treatment

Mailing Address: P.O. Box 80977, Lansing, Michigan 48908

Telephone: (517)376-3229

Fax: (810)496-0073

DO NOT SEND ENTIRE MEDICAL RECORD

Please, send only those records which the patient has authorized, below.

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

Office Phone: _____

Office Fax: _____

I authorize _____, _____
(Doctor/Provider/Clinic Name) (Clinic/Provider Address)

to release medical information for:

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

Patient Telephone Number: (____) _____ **Social Security Number:** _____

Area Code

to the office of Mitchell A. Cohn, D.O. Information will be used for continuity of patient care relating to the following medical condition(s): [Please check all that apply.]

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Agitation of Alzheimer's disease | <input type="checkbox"/> Nail patella | <input type="checkbox"/> Severe Nausea |
| <input type="checkbox"/> Cachexia or Wasting Syndrome | <input type="checkbox"/> Severe and Chronic Pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Severe and Persistent Muscle Spasms | <input type="checkbox"/> Other (Specify): _____ | |

By **INITIALING NEXT TO EACH ITEM, BELOW**, I specifically authorize release of the following:

INITIAL
HERE:

- _____ Clinician office chart notes **[MOST RECENT THREE (3) VISITS ONLY
WHICH PERTAIN TO CONDITION(S), ABOVE]**
- _____ Diagnostic imaging reports (NOT FILMS) **[LAST 3 YEARS, ONLY]**
- _____ *HIV/AIDS related records **[LAST 3 YEARS, ONLY]**

**PLEASE
SEND THIS
FORM WITH
MEDICAL
RECORDS**

Please choose one permission statement, below, and initial only that one.

_____ **You have my permission to FAX the requested information.**

_____ **You may MAIL the information, but NOT FAX it.**

This authorization may be revoked at any time. The only exception is when action has been take in reliance of the authorization. Unless otherwise revoked, this authorization will expire 12 months from the date of signing. I understand that information disclosed by this authorization will not be subject to re-disclosure without my explicit written permission.

FEES: Please bill me for costs, if any, associated with providing copies of my records, and I will remit payment promptly upon receipt of the records.

Patient Signature: _____ Date: _____

Current Health Status Questionnaire & Medical History

Fax, Email, or Post to:

Mitchell A. Cohn, D.O. at M⁴-C

Mailing Address: P.O. Box 80977, Lansing, Michigan 48908

Telephone: (517)376-3229

Fax: (810)496-0073

Email: **Patient.Forms@M4-C.com**

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone # with area code: _____

Mailing Address: _____

Email address: _____

Do you have mobility problems which would necessitate a HOME VISIT? _____

[Please, be aware that there is an additional mileage fee for this service.]

If yes (and you are incapable of coming to our office for your consultation), at what address would you like to have your examination? _____

Current Health Status

Condition(s) for which patient is seeking consultation regarding Medical Marijuana usage:

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Agitation of Alzheimer's disease | <input type="checkbox"/> Nail patella |
| <input type="checkbox"/> Cachexia or Wasting Syndrome | <input type="checkbox"/> Severe and Chronic Pain |
| <input type="checkbox"/> Severe Nausea | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Severe and Persistent Muscle Spasms | <input type="checkbox"/> Other: (Specify: _____) |

1. History of this condition(s): Please describe the condition(s), the date condition(s) first arose, when it was first diagnosed, the cause (if known) and any other pertinent information about the onset of the condition:

1a. If PAIN is a major complaint answer the following: **0=No Pain** and **10=the worst pain you can imagine**:

Least pain you EVER experience: _____ Worst Pain level you ever experience: _____ Average daily pain level: _____

2. Approximately when were you last seen or treated for this condition? _____

3. Is the condition active or in remission? _____

4. What makes your symptoms better? _____

5. What makes your symptoms worse? _____

6. What have you done or tried to resolve this problem? _____

7. What treatment(s) do you receive for your condition? How often? _____

8. Are the treatments having any adverse effects on your health and well-being? (explain): _____

9. Does your condition affect your ability to fall asleep or stay asleep or the quality of your sleep? If yes, please describe:

Medical History

Other than as specified above:

1. Are you currently taking any medications? (Please list all, including over-the counter and prescription medications.): _____

2. Are you allergic or sensitive to any medications? (If yes, please list the medication and the type reaction you have to it): _____
3. Are you allergic to anything else? (If yes, please explain): _____

4. Do you have any respiratory disorders? If so, what? (ex. asthma, COPD, history of lung cancer, etc.)

5. Are you currently being treated for any psychiatric disorders? If yes, what disorder? _____

6. Other than as specified, above, do you have (or have you had) problems with any of the following: **[If yes, please specify the problem, the year it first arose or was diagnosed, and whether it is currently active:]**
 - a. General Symptoms (Fever, chills, night sweats, undesired or unexpected weight gain or loss):

 - b. Heart attack, heart disease, or blood pressure: _____
 - c. Stomach/Intestines/bowel habits: _____
 - d. Kidneys/Bladder/Urinary tract: _____
 - e. Psychiatric or Neurologic disorders (including Numbness, tingling, seizures, paralysis, weakness, depression, or anxiety): _____

- 7. Do you have or have you had any other major illnesses/disorders?
 (Examples include, but are not limited to: Hepatitis, Sexually Transmitted Diseases, Chicken Pox, Herpes, Tuberculosis, Cancer, Arthritis, Gout, Seizures, Diabetes, Thyroid Disease, or Liver Disease).

If yes, please specify the problem and the year it first arose or was diagnosed:

- 8. Please list any surgeries you have had and the approximate year it took place: _____

Social History

- 1. Occupation: _____
- 2. Marital Status (circle one): (Single/Married/Widowed/Divorced/In a stable relationship)
- 3. How many children do you have? _____
- 4. Do you Smoke or chew tobacco in any form? _____ (If yes, circle one: Cigars, Cigarettes, Pipe, Chewing) How much and how often? _____
- 5. Do you consume Alcohol, use Marijuana, or other drugs? _____ If yes, please list type, amount, and how often you partake. _____

Family History

Is there any history in your parents, grandparents, or siblings of Heart Disease, High Blood Pressure, Stroke or any other significant and/or inheritable health disorder (please specify):

Signature: _____ Date: _____

Healthcare Agreement

Fax, Email, or Mail to:

Mitchell A. Cohn, D.O. at M⁴-C

Mailing Address: P.O. Box 80977, Lansing, Michigan 48908

Telephone: (517)376-3229

Fax: (810)496-0073

Email: **Patient.Forms@M4-C.com**

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone # with area code: _____

Mailing Address: _____

Email address: _____

I, _____, understand that Dr. Cohn and M⁴-C are consulting
(Patient)
with me on my healthcare only in regards to my suitability under Michigan law for use of Medical Marijuana as
an adjunct (i.e. additional) treatment for _____.
(Disorder/Disease)

I understand that Dr. Cohn is not, in any way, assuming any other responsibility for my healthcare, including primary care or other specific treatments for the disorder specified, above.

In the event other treatment for this disorder or any other healthcare problem arises, I understand that it is my responsibility to seek and secure treatment from a primary care provider, emergency department, urgent care center, or other appropriate caregiver other than Dr. Cohn or M⁴-C.

Finally, I also understand that payment by me to Dr. Cohn, his employees, or M⁴-C does not guarantee that I will be issued a recommendation for the use of medical marijuana. That determination is made by Dr. Cohn based solely upon my health and qualifications as determined by applicable Michigan Law and Dr. Cohn's professional expertise.

Signature: _____ Date: _____

CURRENT TREATING PHYSICIAN (OR CLINIC):

(If you do not have one, please specify by writing 'NONE'.
If you have more than one, please use an additional sheet.)

NAME: _____ Medical Specialty: _____

COMPLETE ADDRESS: _____

PHONE # (include area code): _____

FAX# (include area code): _____

Fees & Payment Policies

NO Personal Checks

FEES:

- A. Obtaining Medical Records: **NO CHARGE***
*In all cases, the patient is responsible for any fees charged for record copying and/or provision of medical records which may be charged by the provider from whom we are requesting records.
- B. Pre-Visit Record Review: **NO CHARGE**
- C. Consultation (including signed Certificate, if appropriate): ~~\$200~~
ONLY \$129 (for a limited time, only!)

WHEN DO YOU PAY?

You pay NOTHING up front.

Only when you are seen at the office will any fee be collected.

PAYMENT METHODS and POLICIES:

- Acceptable payment methods include
 - **Money Order**
 - **Cash**
 - **Certified Check**
 - **Credit Card (\$7 convenience fee if paying with credit card)**
- No shows or cancellations with less than 24 hours notice are subject to a \$40 cancellation fee.