PATIENT INFORMATION DATE: _____

Legal Name

First: _____ Middle: ____ Last: _____

Phone Number: _____ Cell Phone: _____

Last 4 digits of Social Security: _____ Driver's License Number: _____

Email Contact: _____ DOB: _____

NJMMP Patient ID #: _____

How did you hear about us? _____

In Case of Emergency

Name: _____ Phone: _____ Relationship: _____

Patient's Spouse: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Financial Policy

Thank you for selecting The Green Alternative Doctor/ Dr. Robert Fortino for your healthcare needs. We are honored to provide you with this service. Please be advised that cash payments for all services will be due at the time services are rendered, unless prior arrangements have been approved. We do not accept personal checks or credit cards as payment. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs. I have read and understand all of the above and agree to these statements.

Patient Signature: _____

P: 856.318.4100 | F: 856.827.0029
Info@TheGreenAlternativeDoctor.com

1822 South Broad Street
Philadelphia, PA 19145

Robert Fortino, D.O.

129 Johnson Road, A3
Blackwood, NJ 08012

THE GREEN ALTERNATIVE DOCTOR

Name: _____ Date: _____

Height: _____ Weight: _____ Date of Birth: _____ Age: _____ Marital Status: _____ Sex: M/F/T

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Home / Work / Cell) Email: _____

What is your occupation? _____

How did you hear about us? _____

Do you have medical insurance? (Yes / No) If yes, which company? _____

Do you have a primary care provider? (Yes / No) If yes, please identify:

Name: _____ Address: _____ Phone: _____

Specialist/ Consultant Name and Location: _____

What is/are the main medical problem(s) for which you seek a medical cannabis evaluation? _____

_____

When was the last time you saw your doctor about these complaints? _____

Which treatment modalities have you tried in treating your problems and how effective have they been?

- o Chiropractic Care
- o Acupuncture
- o Surgery
- o Medications
- o Counseling
- o Homeopathy
- o Herbs
- o Osteopathic care
- o Physical Therapy
- o Injections

Psychiatric History

Previous diagnoses: _____

Previous suicide attempts (Yes / No) If yes, give details and dates): _____

_____

Previous psychiatric hospitalizations (Yes/ No) If yes, give details and dates): _____

_____

Current and past psychiatric medications: _____

Substance use history (Yes or No) If yes, please give details on dates, including the specific substance and how frequently used: _____

_____

_____

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Gynecologic History

of Pregnancies: _____ Dates: _____

Natural Delivery or C-Section: (please specify) _____

Date of first day of your last menstrual cycle: _____

Method of Birth Control: _____

Do you smoke tobacco? (Yes / No) If yes, how much and how often? _____

Are you taking any prescription medications or herbs? _____

_____

Do you have any allergies to medications? Please list _____

Have you had any surgeries? (Yes / No) If yes, please list details and dates: _____

_____

Have you ever been hospitalized for medical reasons? Please detail: _____

_____

_____

Please give details with dates of any arrests and convictions

_____

_____

_____

Past Medical History

- Chronic Pain Syndrome
- Blood / Bleeding disorders
- Blood Clots
- Degenerative Disc Disease
- Neurological disorders
- Previous head injury
- Stroke
- Seisures, Epilepsy
- Headaches
- Dizziness / Vertigo
- Cardiovascular disease including atherosclerosis, angina, heart attack, heart failure
- Hypertension
- Heart Murmur
- Abdominal pain
- High cholesterol
- Diabetes
- Thyroid or other Endocrine disorder
- Kidney disease
- Dialysis
- Lung disorders
- Asthma
- Shortness of breath
- Bronchitis, chronic cough
- Tuberculosis
- Depression
- Osteo / rheumatoid arthritis
- Lupus or autoimmune disease
- Immune disorders
- Poor wound healing
- Cancer
- Cancer treatments
- Chemical dependency
- Hepatitis A , B, C
- Hernia

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Do you currently use cannabis for your medical condition? Yes / No / Prior Use

If yes, how many times (circle one): a day / week / month ? _____

What is your preferred method(s) of cannabis use?

Inhaled	Ingested	Suppository	Topical
○ Vapor	○ Tea	○ Vaginal	○ Tincture
○ Smoke	○ Capsules	○ Rectal	○ Cream/ Ointment
	○ Butter/Oil		○ Poultice
	○ Tincture		○ DMSO
	○ Baked Edibles		

Do you or have you frequently experienced any of the following symptoms?

○ Blood in stool	○ Chest pain	○ Constipation	○ Cough
○ Coughing blood	○ Heartburn	○ Eye Problems	○ Easy bleeding or bruising
○ Depression	○ Loss of appetite	○ Fever	○ Pain with urination
○ Diarrhea	○ Nervousness	○ Hearing problems	○ Rectal pain
○ Difficulty swallowing	○ Seizures	○ Heart palpitations	○ Skin rashes
○ Stomach pain	○ Swollen ankles	○ Toothache	○ Vomiting

➢ Initials: _____

Are there health/medical problems that occur frequently in your family? If yes, please explain:

_____

_____

_____

Have you brought with you today medical records or other documents or items that support the medical condition identified above? (Yes / No) If not, why and when will these be obtained?

_____

_____

Patient Signature: _____ Date: _____

Doctor/Nurse Practitioner/Medical Provider initials: _____

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Notice of Privacy Practices for Protected Health Information

This notice describes how medical information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Robert Fortino, D.O. et al respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, health information from other providers, billing, and payment information relating to these services. Federal and state law allows us to use and disclose this information for payment purposes.

Examples of use and disclosures of protected health information for treatment, payment and health operations:

For treatment: Information obtained by a nurse, physician, or other member of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you.

For health care operations: We use your medical records to assess quality and improve services. We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff. We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefits and services. We may contact you to raise funds. We may use and disclose your information to conduct or arrange services to include medical quality review by your health plan, accounting, legal, risk management, insurance services, audit functions, fraud and abuse detection, and compliance programs.

Your Health Information Rights

The health and billing records we create, and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have the right to:

- Receive, read, and ask questions about this notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any written request
- Request and receive from us a paper copy of the most current Notice of Privacy Practices/or Protected Health Information
- Request in writing that you be allowed to see and get a copy of our protected health information
- Have us review a denial of access to your health information, except in certain circumstances
- Ask us to change your health information. You must request this in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. This will not include disclosures to third party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to keep your protected health information private. We will give you this "Notice". We will follow the terms of this "Notice". We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this "Notice". You may receive the most recent copy of this "Notice" by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact the office at 215-336-8000. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the office. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

Patient Signature _____ Date _____

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The Green Alternative Medicine: MMP Disclaimer

I wish to participate in the Medical Marijuana Program in Pennsylvania at The Green Alternative Doctor. I understand and acknowledge that the Medical Marijuana Program in Pennsylvania is **NOT** covered by either federal, state, or private payors and my personal healthcare insurance does **NOT** cover the Medical Marijuana Program in Pennsylvania. I agree not to make a claim for Medical Marijuana Program in Pennsylvania with my personal healthcare insurance carrier. As a result, I further agree and acknowledge that I am fully responsible for all costs of participating in the Medical Marijuana Program. I **must pay cash. Checks are not accepted for services rendered by The Green Alternative Doctor.**

By signing below, I accept and acknowledge that I am opting out of using my healthcare insurance for the Medical Marijuana Program in Pennsylvania. I accept paying cash for these services.

Acknowledged and accepted by patient or, as applicable, responsible party.

_____	X_____	_____
Patient Name	Signature	Date
_____	X_____	_____
Representative / Responsible Party	Signature	Date

1822 South Broad St
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If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you. The Registry ID# and the Reference # will be given to you in the office if you are enrolled in the program.

Our Commitment to You: As our patient, you are very important to The Green Alternative Doctor. We promise to provide you with excellent care.

- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment.
- We will be mindful of your time by being efficient and minimizing wait time.
- If circumstances beyond our control arise, we will reschedule your appointment to an earlier time or date if we have a cancellation in our office schedule.

General Information: Our offices get very busy. It is very important that you keep your appointment and arrive 10 minutes before your scheduled time.

- If you have an emergency and cannot keep your appointment, you must contact our office no later than **48 hours** prior to your scheduled appointment date.
- We will charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- If you are a new patient and provided a deposit, you will forfeit that deposit if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- Without the completed documents, films, test, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    - Photo ID
    - MRI films and reports, CT scan films and reports, bone scan reports, EMG reports
    - Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
    - List of current medications.

Financial Policy: We are committed to providing you with the best possible care. In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.

- Payment is due in full at the time of service, unless you have made payment arrangements in advance.
- Only cash will be accepted as payment.
- We do not accept insurance.

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Missed Appointments: Please help us serve you better by keeping scheduled appointments.

- **Unless cancelled at least 48 hours in advance,** our policy is to charge a $25 **NO SHOW FEE** for missed office appointments for existing patients and new patients (which includes losing your deposit).

I have read, understand, and agree all the Policies above. I GUARANTEE payment of all charges incurred for this account. I further agree to pay any attorney's fee, court cost, and related collection fees incurred as a result.

_____ **X**_____ **Date**_____

Patient Name **Signature**

_____ **X**_____ **Date**_____

Representative/Responsible Party **Signature**

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