(267) 608-5368
CLINIC@JEWISHSAUCEBOSS.COM

INTRODUCTIONS & DISCLOSURES:

This document has been prepared to serve as an introduction between Jewish Sauce Boss, LLC ("JSB," "We") and Doctor Matthew Schwartz (d/b/a "MyHealth360.org," "The Doctor") and an individual ("You," "The Patient") requesting official certification into the Pennsylvania Medical Marijuana Patient Program and by completing this document:

Patient Initials:

_____ The Patient agrees and certifies that this inquiry has been made "for The Patient, by The Patient" and that the individual named above and throughout this application is the same and sole individual in receipt of all communications and plans to attend the formal telehealth consultation appointment and receive certification into the PA Medical Marijuana Patient Program

Unfortunately, we are unable to accept or honor third-party or caregiver inquiries at this time.

_____ The Patient understands that as a part of this discovery and intake process they will be required to properly and honestly identify themselves using personal identification and contact information, including their legal name, social security number, date of birth, and other common medical provider intake information.

_____ The Patient understands that this approval process for acceptance into the PA Medical Marijuana Patient Program is not an immediate one and depends on the final turnaround/approval from the Pennsylvania Department of Health.

_____ The Patient understands that they will be required to provide proof of their medical history, previous diagnosis information, and/or any past or present prescription info, labels, or bottles as "proof of diagnosis" or to aid in the qualification of condition.

_____ The Patient understands that in order to meet with Doctor Schwartz they must first apply for a PA Medical Marijuana Patient ID number with the PA Department of Health, online and via computer device only. (The PA DOH form/online system is not compatible with mobile devices.)

That form is available at:
https://padohmmp.custhelp.com/app/adult-patient-registration

_____ The Patient understands and agrees to the following cost of service: New Patient Certification is billed at the rate of $165 and not covered by any private or government health care insurance providers. Annual Patient Re-Certification is billed at the rate of $85 and not covered by any private or government health care insurance providers. And, all payments are due in full (electronically) at the time of appointment booking.

_____ The Patient understands that an additional payment of $50 will be due, payable and sent to the PA Department of Health, following any approval from Doctor Schwartz to enter the PA Medical Marijuana Patient Program.

_____ I understand that no doctor/patient relationship has been established with Dr. Schwartz, solely on the basis of this certification and that no claim can be made against Dr. Schwartz reflecting any reliance on him for any other health advice or care beyond recommending medical cannabis based upon the medical information provided to him.

_____ The Patient agrees and certifies that the information above and throughout this document is and will be deemed true and accurate to the best of their knowledge.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This section of the document authorizes the release of personal and medical information:

First Name:	Last Name:
Street Address:	City, State, Zip:
Phone Number:	Email Address:
DOB:	SSN:

FROM (PRIMARY CARE PROVIDER) May Leave Blank

PCP Name:
Physician:
Address:
Address:
Phone: Fax:

TO:

Jewish Sauce Boss

Dr. Matthew Schwartz

417 South St,

Philadelphia, PA 19147

(267) 608-5368

"I AUTHORIZE THE RELEASE OF…" (CHOOSE ONE):

☐Immunization Records Only
☐Only records from ____ / ____ / _____ to ____ / ____ / _____
☐Only records related to the following conditions: _____

Specifications can include: "Specific issues/diagnosis," "Problem lists," "Progress notes," "X-Ray or Radiology reports and records," "EKG/Cardiac reports," "Physcial exam history," "Medical clearance," etc.

INCLUDING RECORDS RELATED TO:

☐Mental Health ☐Drug/Alcohol Treatment ☐HIV/AIDS ☐Communicable Treatment

I HEREBY…

- Understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- Understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing ad present my written revocation to the health care providers named above, except to the extent that the health care providers named above have already taken action based upon my authorizations. Unless otherwise revoked, this authorization will expire 6 months from the date of signature.
- Understand a copy of this form is available to me upon my request.
- Understand that any private medical information, including HIV-related information and/or behavioral health documentation may be revealed with this disclosure of health information.
- Understand there may be a charge for medical record photocopying, faxing, or other types of transmission including electronic.

I have read this entire form and all my questions about this form have been answered. By signing below, I acknowledge that I accept all of the above:

Patient Signature: Date:

PATIENT REGISTRATION

PA MMJ Patient Number: _____

First Name: Last Name: MI:

Street Address:

City: State: Zipcode:

Home Number: Cell Phone: Email:

Gender: Height: Weight: DOB:

☐I am single. ☐I am married. ☐I am separated. ☐I am divorced. ☐I am widowed.

☐I have a commercial drivers license. I was referred by: _____

PLEASE DESCRIBE THE CHIEF CONDITION, DIAGNOSIS, OR SITUATION:

Pain Level (1-10): On-set problem:

MY INFECTION HISTORY INCLUDES:

☐Hepitis ☐HIV/AIDS ☐MRSA ☐Bone/Joint Infection ☐Surgical Site Infection ☐Something else

CHRONIC & PRE-EXISTING CONDITIONS (CIRCLE ALL THAT APPLY):

Diabetes Hypertension/HBP Heart Disease Cardiac Stents Heart Arrhythmia

CABG/Heart Bypass Pacemaker/Defibrillator Emphysema/ COPD Asthma/Bronchitis

Pulmonary Embolus Blood Clots/DVT Sleep Apnea (CPAP) Anemia Blood Transfusion

Cancer Reflux/Ulcer Seizures Something else:

SOCIAL & RECREATIONAL DRUG USE:

☐I have never smoked. ☐I smoke cigarettes. ☐I vape tobacco products. ☐I use snuff. ☐I quit tobacco

☐I have used cannibis. ☐I've used cocaine. ☐I've injectable drugs. ☐I've used meth.

☐I drink alcohol. ☐There's something else I'll disclose during the consultation.

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT HAVE SIGNIFICANTLY AFFECTED YOU)

MUSCULOSKELETAL

Joint Pain
Join Swelling
Joint Stiffness
Muscle Pain
Instability

NEUROLOGICAL

Numbness
Dizziness
Nervousness
Anxiety
Seizures
Tremors
Balance
Distributions

RESPIRATORY

Shortness of Breaht
Wheezing
Coughing

GASTROINTESTINAL

Heartburn
Nausea
Vomiting
Constipation
Diarrhea

SKIN

Skin Changes
Poor Healing
Rash / Itching

RENAL

Difficult/Painful Urination
Frequent/Urgent Urination

GENERAL

Unexpected Weightloss
Unexpected Weightgain
Fever/Aches/Chills
Fatigue

CARDIOVASCULAR

Chest Pain
Palpitations
Fainting

PREVIOUS OPERATIONS (PLEASE LIST)

Type:	Year:	Reason:

CURRENT MEDICATIONS (PLEASE LIST)

Name:	Dose:	Reason:

ALLERGIES TO MEDICATIONS, SOLUTIONS, METAL, ETC. (PLEASE LIST)

Substance:	Reaction/Experience:

FAMILY MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

Cancer Diabetes Epilepsy Heart Disease High Blood Pressure

Psoriasis Congenital Problems Obesity Asthma Alcoholism

Tuberculosis Thyroid Problems Rheumatic Fever Rheumatoid Arthritis Stroke

Something else:

Patient Name (Printed) Patient Signature Date

MORE STEPS ON NEXT PAGE WHILE SCANNING

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SCAN: FRONT OF PA STATE ID/DRIVERS LICENSE

SCAN: BACK OF PA STATE ID/DRIVERS LICENSE