reTHINK CANNABIS is a service of CGS PHYSICIAN SERVICES

CONSENT FOR MEDICAL TREATMENT

Patient Name: J _____ Date of Birth: _____

_____ I hereby authorize Charlene Shaw, DO and/or such assistants as may be requested by said physician to perform the above noted medical treatment as explained to me. I am seeking treatment for the purpose of relieving symptoms related to my qualifying condition. I have reviewed medical alternatives as well as understand the potential risks/ benefits/ potential side effects of medical cannabis as well as potential drug interactions and acknowledge that the benefits of medical cannabis outweigh its use.

I understand that cannabis may impair my ability to drive by having an effect on my coordination, motor skills, and cognition; as a result, I should not operate heavy machinery or operate a motor vehicle while under the influence of medical cannabis.

I understand that although medical cannabis is legal in the States of Florida and Pennsylvania, there may be implications in my workplace if it is prohibited and that may include termination of employment. I acknowledge that cannabis is allowed for medical treatment under Florida and Pennsylvania statutes; however, it is considered to be illegal by the Federal Government (despite its classification as a schedule III drug) and I assume all risks and responsibilities. I confirm an understanding that my de-identified health information contained in the physician certification and medical use registry may be used for research purposes.

I understand that if I am at risk of becoming pregnant I will use a form of contraception or abstain from using medical cannabis. I understand medical cannabis is contraindicated in pregnancy or while breast feeding so female patients who become pregnant or are/intend to breastfeed should immediately discontinue use of all medical cannabis products.

I understand the purpose of this consultation is to assess the risk versus benefits of medical cannabis in relationship to my qualifying condition. I understand this evaluation should not replace any screening or follow up with my primary care physician or other consultants.

I understand that there is no scientific data regarding specific dosing of CBD (cannabidiol) or medical cannabis and that the physician only provides a recommendation per state guidelines specifying a maximum dose per day.

I understand that if I experience any adverse side effects then I will stop using medical marijuana immediately and go to the emergency room for further evaluation.

I agree to comply with the Florida and/or Pennsylvania rules and regulations listed under the Medical Marijuana Use Registry/Program respectively.

_____**I assume full medical and legal responsibility for any and all legal and health risks associated with the use of medical marijuana as a treatment option.**

RIGHT TO DISCONTINUE SERVICES

_____CGS Physician Services, LLC reserves the right to decline new patients, refuse specific services, or discontinue an existing professional relationship when clinically appropriate or otherwise permitted by law. Such decisions may be based on medical appropriateness, scope of practice, availability, patient conduct, or other legitimate professional considerations. All decisions will be made without unlawful discrimination and in accordance with applicable laws and professional standards. When an established patient relationship is discontinued, appropriate notice and reasonable provisions for continuity of care will be provided as required.

Patient or Responsbile Party Signature	Date