

CELEBRATING 30 YEARS



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 entirety 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.***

## Patient Information

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ 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: \_\_\_\_\_  
Cell #: \_\_\_\_\_ Home#: \_\_\_\_\_ Work #: \_\_\_\_\_  
Address: \_\_\_\_\_  
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 Information

Name of Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
**Policyholder Information - If you are the policyholder, check this box  and skip to the next section.**  
Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_

## Secondary Insurance Information

Name of Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
**Policyholder Information - If you are the policyholder, check this box  and skip to the next section.**  
Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_

## Work / Auto Related Injury

Is this the result of an accident:  Auto  Work Date of Injury/Accident: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Contact Name/Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Claim Number: \_\_\_\_\_ Insurance ID Number \_\_\_\_\_  
If Auto Accident, State where injury occurred: \_\_\_\_\_  
If Work Injury, Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
County: \_\_\_\_\_ Contact Name/Phone: \_\_\_\_\_  
Address where injury occurred: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Job Duties: \_\_\_\_\_  
Adjuster Handling Claim (Name/Phone): \_\_\_\_\_  
Attorney Handling Claim (Name/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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<input type="checkbox"/> Driver	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Ambulance:	<input type="checkbox"/> C-Collar
<input type="checkbox"/> Passenger Front Seat	<input type="checkbox"/> Airbags deployed		<input type="checkbox"/> Backboard
<input type="checkbox"/> Passenger Back Seat	<input type="checkbox"/> Seatbelt	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:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Relative	Relative	Relative
<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Alcohol Abuse _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Drug Abuse _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feed yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clean your house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care for your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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: \_\_\_\_\_ DOB: \_\_\_\_\_

## 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: \_\_\_\_\_ DOB: \_\_\_\_\_

**Medication Intake Sheet**

Please list **ALL** medications taken on a daily basis.  
This includes all **vitamins, herbals and over-the-counter medications.**

Medication Name	Dose / Strength	Times taken per Day	Prescribing Doctor	Reason for Taking Medication

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

Medication: \_\_\_\_\_ Who Prescribed: \_\_\_\_\_

**Please list ALL Medication Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Pharmacy Address (if known): \_\_\_\_\_



**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.**

**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

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** \_\_\_\_/\_\_\_\_/\_\_\_\_

\* If above is unsigned, this is a blank copy for patient to keep after e-signature was obtained during office visit.