PMC Medical Group, LLC

Therapeutic Cannabis

CONSENT for Therapeutic Cannabis Treatment

I,_____, ("Patient") am requesting _____ ("Provider") to certify me/ my child/ my legal ward as a qualifying patient under NH RSA 126-X Use of Cannabis for Therapeutic Purposes and to treat patient's debilitating medical condition as patient uses cannabis for medical purposes. In requesting the provider to continue treating patient, as patient uses cannabis for medical purposes, I assume full responsibility for any and all risks of this action.

I understand that cannabis is not approved by the Federal Food and Drug Administration for medical purposes and may contain unknown quantities of active ingredients and may contain contaminants and/or impurities. I understand that the provider may not be knowledgeable of all the associated risks involved in the use of a non- FDA approved substance such as cannabis. I acknowledge that there is controversy in the scientific/ medical literature available regarding the usage of cannabis for medical purposes and that more research is currently being conducted.

I understand that, although New Hampshire law has approved the limited use of cannabis for medical purposes, its use is not approved under federal law. The current and future enforcement actions of federal law enforcement officials are uncertain.

I understand that the use of cannabis for therapeutic purposes and the process of certification is **NOT** a service covered by medical insurance. I acknowledge that payment is due at the time of service in the form of cash or debit/credit card; **NO** personal checks will be accepted.

Patient Name:_____ DOB:_____

Signature of Patient /Legal Guardian:_____ Date:_____

(Legal Guardian Printed Name) _____