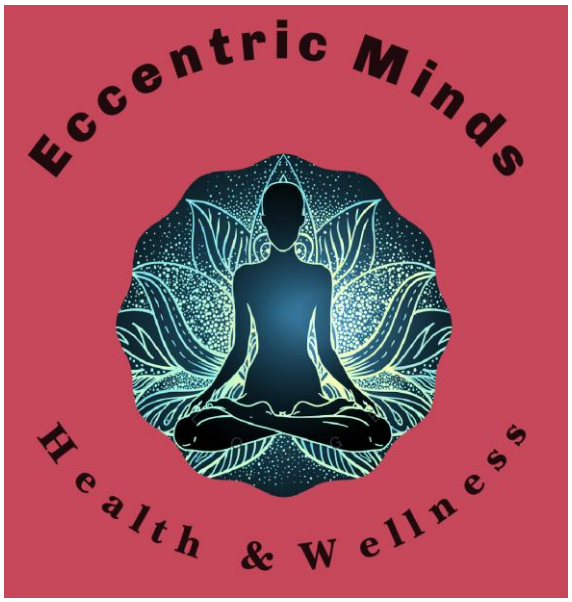

Medical Marijuana Patient Agreement

Please read each statement below and sign in the appropriate spaces to indicate that you understand and agree with the information relating to Medical Marijuana (sometimes referred to as "Cannabis"). Do not sign this agreement and do not use Medical Marijuana if you have questions about or do not understand the information below.

Acknowledgments of Disclosure and Informed Consent

I understand that I am being evaluated for a physician's recommendation for Medical Marijuana and that the practitioner will make this assessment based, in part, on the medical information I have provided. I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical Marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes.

I understand side effects of Medical Marijuana can include but are not limited to:

- Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation.

- I understand Cannabis may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration ("FDA") and was produced without FDA oversight for health, safety, or efficacy. Cannabis may contain unknown quantities of active ingredients, impurities, or contaminants.
- I understand that smoking Cannabis is not permitted under Virginia law and may be hazardous to your health and that Cannabis Smoke contains carcinogens and may lead to an increased risk of cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.
- I understand that the efficacy and potency of Cannabis may vary widely depending on the Cannabis strain and ingestion method.
- I understand that when Cannabis is eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.
- I understand that there exists the possibility of becoming dependent on Cannabis and that I may experience withdrawal symptoms when I stop using Cannabis.
- I understand that I may develop a tolerance to Cannabis. This means higher and higher doses might be required to achieve the same symptom relief.
- I understand that a recommendation for medical marijuana does not provide me with any legal protection relating to the cultivation and/or processing of marijuana.

- I understand that Cannabis may exacerbate schizophrenia or bipolar disorder in persons predisposed to those disorders.
- I understand that women should not consume Cannabis products while planning to become pregnant, during pregnancy, or while breastfeeding.
- I understand that using Cannabis while under the influence of alcohol is not recommended and may have unexpected and dangerous side-effects.
- I understand that the use of Cannabis may affect coordination, cognition, and judgment. While under the influence of Cannabis, I will not drive, operate machinery, or engage in potentially hazardous activities.
- I understand and acknowledge that my patient information will be provided to the Virginia State Board of Pharmacy so that I can be added to the Patient Registry.

Patient Attestations

- I agree to strictly comply with the regulations, terms, and conditions of the State of Virginia's Medical Marijuana Program set forth by Virginia Code 54.1- 3408.3
- I agree to only obtain Medical Marijuana from dispensaries licensed to operate under the rules governing by the State of Virginia's Board of Pharmacy.
- I understand that it is my responsibility to ensure no Cannabis obtained by me shall be used for any other purpose than as directed by my certifying physician and such Cannabis is not resold, distributed, or otherwise possessed or used by any other person.
- I understand that Virginia Marijuana Card makes no guarantee regarding product availability and pricing at licensed Virginia dispensaries.
- I am not pregnant, intending on becoming pregnant or breastfeeding. (For Female patients)
- If I start using Cannabis, I agree to tell my physician if I experience any one or more of the following:
    1. Start to feel sad or have crying spells
    2. Have changes in my normal sleep pattern
    3. Lose my appetite
    4. Become more irritable than usual

5. Withdraw from family and friends
6. Become pregnant

In the event that I experience a severe adverse reaction, I agree to immediately contact 911 for help.

- I hereby acknowledge Eccentric Minds Health & Wellness PLCC and its employees and contractors, are not addressing specific aspects of my medical care nor are any of them my primary care provider.
- Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Eccentric Minds Health & Wellness PLLC, and its principals, agents, and employees free of any responsibility and free of any harm resulting to me and/or other individuals because of my Medical Marijuana recommendation or use.
- In using Medical Marijuana, I fully accept responsibility and assume the risks and side effects associated with its use.
- I agree that Eccentric Minds Health & Wellness PLLC and employees shall not be held responsible for any harm resulting to me and/or any other individual(s) because of my use of Medical Marijuana.
- I agree that Eccentric Minds Health & Wellness PLLC, employees, and contractors shall not be held responsible in any manner relating to any legal issues that arise as a result of my use of Medical Marijuana.
- I certify that I have read this document and declare under penalties of perjury that the information contained herein is true, correct, and complete_____ (Please Initial Here)

By signing below, I hereby certify that I have read, understand, and agree with the terms set forth in This Agreement.

SIGNATURE_____ **DATE_____**

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Payment Policy

Services Under Annual Fee

Eccentric Minds Health & Wellness PLLC charges a one-time evaluation fee that covers patients for a full calendar year from a Physician/Nurse Practitioner who is lawfully certified to recommend Medical Marijuana in the State of Virginia under strict compliance with the rules and regulations governed by the Virginia State Board of Pharmacy. There will be no additional fees charged for any follow-up appointments for 12 months following the date of the initial evaluation. All services rendered by physicians and Nurse Practitioners working with Eccentric Minds Health & Wellness PLLC are only conducting the evaluation for eligibility of medical marijuana, and the Physician/Nurse Practitioner shall not be considered the patient's primary care provider.

Fees

Annual Medical Marijuana Evaluation - Pricing varies please refer to prices listed on Website for up-to date pricing or call 757-333-0175 and speak to a receptionist to learn about all discounts and offers. SSDI/SSI and Veteran discounts with verifiable documentation are available but must be noted at the time of booking.

Annual Patient Registry Fee - The Virginia State Board of Pharmacy requires a $50 annual registration fee for a patient to obtain their medical marijuana card. This fee is paid directly by the patient to the State Board of Pharmacy after the application has been submitted by the patient. This fee is not associated with Eccentric Minds Health & Wellness and we do not make this payment on the patient's behalf.

Payment Due at time of scheduling appointment

We require that payment be rendered at time of scheduling appointment. No exceptions to this rule.

Forms of Acceptable Payment

Eccentric Minds Health & Wellness PLLC accepts **credit or debit card payments only**. Any form of private insurance, Medicare, or Medicaid is not accepted as marijuana is a Schedule 1 drug and not honored by any insurance**. Important:** Your credit card statement will state: Eccentric Minds MMC Consultation.

Refund Policy

A full refund will be issued if your appointment is canceled 48 hours prior to the scheduled appointment date and time. Appointments cancelled less than 48 hours prior to the scheduled appointment date and time will not be refunded under any circumstance, but you will be given opportunity to reschedule for no additional charge. However, no refund will be offered if the appointment is missed without a call placed for cancellation by responsible party, under that circumstance the appointment may be re-booked for a fee of $50. Patients who do not complete the required yearly intake form will be rescheduled at the next available/agreeable appointment date and time and are not eligible for a refund. If you are rescheduled because you didn't have your documentation completed for your original appointment date and time you are not eligible for a refund.

Eccentric Minds Health & Wellness makes no guarantees with regard to a patient's eligibility for Virginia's medical marijuana program, and it is the patient's responsibility to provide sufficient information regarding their serious medical condition. We will make reasonable effort to advise/guide you with requesting pertinent documents from your PCP. If a practitioner cannot recommend a patient for medical marijuana because the patient did not submit truthful information then no refund will be provided.

CONSENT FOR TELEMEDICINE CONSULTATION

I understand that Eccentric Minds Health and Wellness PLLC requires me to engage in a telemedicine consultation. Eccentric Minds Health & Wellness PLLC has explained to me how video conferencing technology used for such a consultation will not be the same as an in-person visit because I will not physically be in the same room as my provider.

I understand that a telemedicine consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing during this COVID-19 pandemic. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
I will have a direct conversation with my recommending physician during which I will have the opportunity to ask questions regarding this process. My questions will be answered and the risks, benefits, and any practical alternatives will be discussed with me in a language in which I understand.

By signing this Agreement form, I certify that:

I have read or had this form read and/or had this form explained to me.
I fully understand its contents including the risks and benefits of this technology.
I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY ELECTRONICALLY SIGNING THIS AGREEMENT, I CONFIRM I HAVE READ, UNDERSTOOD, AND CONSENT TO THE ITEMS CONTAINED IN THIS DOCUMENT.

SIGNATURE_____ **DATE**_____