



Holistic Medicine & Skin Care
1670 Route 34 N., suite 3C
Wall Township NJ 07727

Welcome to MD Wellness New Jersey Medical Marijuana Program

The New Jersey Medical Marijuana Program (NJMMP) accepts patients with the following qualifying conditions:

1. Amyotrophic lateral sclerosis (ALS)
2. Multiple sclerosis (MS)
3. Muscular dystrophy
4. Inflammatory bowel disease, including Crohn's disease or ulcerative colitis
5. Terminal illness, if the physician has determined a prognosis of less than 12 months of life.
6. Seizure disorder
7. Intractable skeletal muscular spasticity
8. Glaucoma
9. Positive status for human immunodeficiency virus (HIV)
10. Acquired immune deficiency syndrome (AIDS)
11. Post-Traumatic Stress Disorder (PTSD)
12. Anxiety
13. Chronic Migraines
14. Chronic pain of visceral origin
15. Chronic pain related to musculoskeletal disorders
16. Tourette's Syndrome
17. Opioid Use Disorder, as an adjunct to Medication Assisted therapy
18. Dysmenorrhea (menstrual cramps)
19. Cancer
20. Epilepsy

If you are already diagnosed by another physician, you must bring one of the following documents;

- MRI report or other imaging report
- Operative report
- Psychotherapy evaluation/progress notes
- Official letter from your physician with diagnosis with the physician's letterhead, with license, address, phone number, NPI number or a prescription stating your diagnosis.

The NJ MMP also requires the following documentation:

- Patient photograph
- Proof of Identification (Current New Jersey Driver's License or Government Issued Photo ID).
- One utility bill issued in the past 90 days and must match your name on your proof of identity (water, electric, gas, cable, internet, phone, sewer, cell phone), One tax related document issue in the past year (W2) or 3 bank statements from the past 3 months
- Social Security Number, last 4 digits

NOTE: if your address does not match your form of ID, a second proof of address is needed. Example: two different bank accounts, etc.

For Caregivers Only:

All primary caregivers **must register** with the New Jersey Medicinal Marijuana Program and submit a required fingerprint submission and background check.

To become a patient's primary caregiver, you must:

- Be a New Jersey resident
- Be 18 years of age or older
- Agree to assist a qualifying patient with the medical use of marijuana
- Not be the patient's physician
- Submit to a criminal history/background check

*If you chose to sign up a caregiver please be aware a caregiver must get a criminal background check through fingerprints. There is a form on the bottom of the page where you upload your documents to print. On this form, it will have the information needed on how to make an appointment for fingerprints.

Caregivers must provide all the necessary documents require by the State listed on this page

DOCTOR'S OFFICE VISITS, PRESCRIPTION RENEWALS, STATE FEE AND IN OFFICE REGISTRATION. (REGISTRATION IN OFFICE IS OPTIONAL)

Patients already diagnosed by another physician will be charged a \$250 evaluation and processing fee. Patients without a diagnosis will be charged \$350 for evaluation and processing fee. **Disabled veterans** will be charged a discounted fee of \$150.

of your appointment. **The state of New Jersey requires an additional fee of \$100 for your ID card, which you will pay directly to NJ approximately 2-3 weeks after your application is submitted.** Certain patients (see below) are eligible for a state discount on this card. The state will contact you by email and ask for payment at that time. After you receive your ID card, you can use this card to purchase your medical marijuana from the dispensary of your choice.

Renewals:

After entering in the **NJMMP** system, you will be required to be evaluated by Dr. Rothman every 90, 180 or 360 days in order to keep your prescription valid. Phone consultations are available for this service.

- **90 days prescription renewal \$100**
- **180 days prescription renewal \$175**
- **360 days prescriptions renewals \$300**

Government Assistance-if applicable, fees:

Patients and caregivers if qualified and approved for the state and federal assistant programs listed below are eligible to pay a discount fee of \$20 for their NJ MMP ID card. **Each registration period is valid for two years.**

- NJ Medicaid Program
- Food Stamps Benefit (SNAP)
- Social Security Disability Benefits (SSD award letter)
- Social Security Income Benefits (SSI award letter)
- NJ Temporary Disability Insurance Benefits
- Seniors over 65 years old
- Veterans identification card
- DD form 214/DD form 2

Your NJMM card is valid for two years. When you renew after 2 years you must resubmit all the same documentations issued during your initial visit (which must be up to date), except for your medical record. A \$50 fee will be charged to renew your card if done by our office or you can do the renewal yourself on line free.

DISPENSARY GUIDE

Dispensary/Phone Number	Dispensary location
Harmony Foundation 201-356-7268	600 Meadowlands Parkway Suite 15 Secaucus, NJ 07094
Breakwater Alternative Treatment Center 732-703-7300	2 Corporate Drive Cranbury, NJ 08512
Curaleaf NJ, Inc. 856-933-8700	111 Coolidge Avenue Bellmawr, NJ 08031
Garden State Dispensary 848-999-2005	950 US HWY 1 North Woodbridge, NJ 07095
Greenleaf Compassion Center. 973-337-5670	395 Bloomfield Avenue Montclair, NJ 07042
The Botanist by Compassionate Care Foundation 609-277-7547	100 Century Drive Egg Harbor Twp., NJ 08234
Columbia Care 856-213-9445	1062 N Delsea Drive Vineland, NJ 08360
Rise 973-440-2717	196 3 rd Avenue Paterson, NJ 07514
Zen Leaf 908-280-8642	117 Spring Street Elizabeth, NJ 07201
The Botanist by Compassionate Care Foundation 609-454-6846	1301 Boardwalk Atlantic City, NJ 08401

Note: if you chose our staff to register you for the NJMMP and fail to provide all the documentation listed on this form at the time of your visit, they will not be able to enter you in the program until you provide all documentations. After being registered, all communication will be between you and the State. Make sure to check your email and your spam folder after 2-3 weeks after registration. For questions regarding your application status call the NJ State at; (609) 292-0424 .Make sure that you have your registration reference number on hand. The

reference number is a combination of letters and numbers at the top of your registration form copy provided by our office.

If you fail to provide all the requested documentation required by the state and get denied, the amount you paid for the office services including the doctor's visit will not be refunded.

Sign _____ **Date** ____/____/____

PERSONAL INFORMATION:

Your Name: (same as on your Driver's license)	Last/Middle Initial:	First:
DOB:	Month/Day/Year:	Age:

Driver License Number:	
Last 4 digits Social security #	
Address:	Address: _____ City: _____ Apt/Suite: _____ State/Zip: _____
Contact Number:	
Email Address:	
Referral:	
Are you a veteran?	_____ YES NO _____
Are you on?	PLEASE CHECK ONE OR ALL THAT APPLY _____ Medicaid (NJ Family Care) _____ Supplemental Income (SSI) _____ NJ Temporary Disability Benefits _____ Social Security Disability _____ Food stamps

MEDICAL SERVICES AGREEMENT

_____(PATIENT) and MD Wellness (Dr. Michael E Rothman.) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT agrees not to submit a health insurance claim (or request the PHYSICIAN to submit a claim on PATIENT'S behalf) under the Social Security Act (MEDICARE) for the services, even if you may think that such services are or maybe otherwise covered under health insurance or MEDICARE.
2. **The PATIENT agrees to be responsible for the SERVICES.** Although metabolic balancing therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or metabolic balancing therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General takes the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government.
3. The PATIENT acknowledges that health insurance companies or "Medicaid plans" (42 U.S.C., section 1882) will not provide reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a, 1848g) will apply to the amounts PHYSICIANS charge for their SERVICES.
4. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.
5. Our **INVOICE** contains pertinent information regarding your office services and purchases. This form was generated for your personal records only although; patients have submitted it to their insurance company with a claim form for reimbursement. **This frequently causes subsequent inquiries by the insurance company to which we do not respond.**

Patient's Signature _____

Date: _____/_____/_____

Notice of new HIPAA Guidelines for MD Wellness Patients

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your medical

reports, appointment confirmations and/or receivables of lab results:

I wish to be contacted in the following manner(s):

Home Phone ☐

Leave message with detailed information
Leave message with call back number

() _____

Home number

Mobile Phone ☐

Leave message with detailed information
Leave message with call back number

() _____

Mobile number

E-mail Report ☐

e-mail address

Written Communications ☐

Please continue to send to my home

Mailing Address

Print full name

Patient's signature

Today's Date _____ / _____ / _____

Insurance Disclaimer

Dear Patient,

Medical Marijuana is a unique and rapidly growing form of alternative medicine, which is not recognized by the insurance industry. It is viewed as a form of General Health and/or Aesthetic Medicine making it a non-reimbursable service.

More so, due to both state and federal issues relating to billing for office visits, we have been advised by legal counsel to disassociate from all forms of third-party insurance programs. We therefore, are not contracted or participate with any insurance companies and CAN NOT supplies the following:

1. Insurance billing forms.
2. Standardized Service codes.
3. Standardized diagnostic codes.
4. Transmit any information to any insurance company or their representatives.

NEW JERSEY MARIJUANA PROGRAM DISCLAIMER

I agree to participate on Medical Marijuana Program at MD Wellness in New Jersey, and I understand and acknowledge that Medical Marijuana Program is not covered by any private healthy care, Federal and private payors. I acknowledge that my personal healthcare insurance does NOT cover Medical Marijuana Program in this state. I agree that I must pay cash or major credit card, and I agree NOT to claim to my personal healthcare cost related to my Medical Marijuana Program expenses.

By signing this form, I am agreeing to pay for all my expensive out of pocket and I am opting out of using my healthcare insurance for these services.

Print full name

Patient's signature

Today's date ____/____/____

RISKS OF USING E-MAIL

The physician offers patients the opportunity to communicate by e-mail. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via e-mail without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of e-mail communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.

- E-mail is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail once it has been sent.
- E-mails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- E-mail can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. E-mail senders can easily misaddress an e-mail, resulting in it being sent to many unintended and unknown recipients.
- E-mail is indelible. Even after the sender and recipient have deleted their copies of the e-mail, back-up copies may exist on a computer or in cyberspace.
- Use of e-mail to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- E-mail can be used as evidence in court.
- The physician uses encryption software as a security mechanism for e-mail communications.

Conditions of using e-mail

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of e-mail communication.

- The patient is responsible for informing the physician of any types of information the patient does not want to be sent by e-mail. Such information that the patient does not want communicated over e-mail includes:

The patient can add to or modify this list at any time by notifying the physician in writing.

The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by e-mail. I acknowledge the physician's right to, upon the provision of written notice; withdraw the option of communicating through e-mail. Any questions I may have had were answered.

Patient's signature: _____ **Date:** _____ / _____ / _____

MEDICAL MARIJUANA PROGRAM PATIENT CERTIFICATION

Please initial the following:

I certify that I understand and have been advised by my physician of the following:

____ Marijuana has both sedative and addictive attributes

____ There are alternative treatments for my condition

____ I voluntarily choose to participate in this program

____ I am free to withdraw from this program and cease using this product at any time

____ I understand that I should not operate heavy machinery or a vehicle while using this product.

____ I understand that when using this product, I must comply with all the provisions of P.L. 2009, c.307.

____ I understand that my right to use this product may not be recognized by other states and that I will have no immunity from law enforcement should I use this product outside the state of New Jersey

____ I additionally authorize the release of my name and date of birth to law enforcement, to confirm identity, only if law enforcement has provided the Medicinal Marijuana Program with my valid registration number.

If you chose to sign up a caregiver please be aware a caregiver must get a criminal background check through fingerprints. Registration fees will not be set to your account until your caregiver's criminal background check is cleared. Also, a caregiver will have to pay a registration fee as well as the patient for their identification card.

My signing this form, I attest that the information I have entered on this form is true and accurate. I acknowledge that I have read and fully understand this consent form.

Full Name

Patient's Signature

Today's Date ____/____/____

MD WELLNESS MMP APPOINTMENT CANCELLATION, CHANGE AND "NO-SHOW" POLICY

At MD Wellness, we strive to provide excellent patient care and customer service. Also, we do NOT overbook the schedule (unlike most other doctor's offices) at MD Wellness and therefore waiting times are usually nonexistent or very short. (rarely more than 15 minutes)

Dr. Rothman's services are in very high demand, and his schedule is now filling up weeks in advance. Many people are seeking his care to help them solve their chronic health related issues.

Unfortunately, we are experiencing a large amount of "no-shows", and "last minute" cancellations and changes to our schedule. The Doctor's time is scarce and valuable and when you make an appointment with him, this time is reserved just for you. These last-minute changes are very problematic, creating large "holes" in our schedule while simultaneously depriving other patients the chance to see Dr. Rothman.

We are therefore announcing a new policy at MD Wellness to help mitigate against these scheduling problems;

- 1. New patients will pay a \$50 deposit for their visit at the time they make their initial appointment. Any changes for a new patient must be made at least three (3) MD Wellness business days advance or you will forfeit your deposit. Payments must be in the form of credit card or cash.**
- 2. Returning patients will be subject to a \$35 cancellation fee unless 48-hour advanced notice is given. No-shows will be charged a \$50 fee.**
- 3. Patients that are chronic offenders will be required to pay for their visit in full in advance. Payment will be forfeited if late cancellation or no show, or you may not be offered future appointments.**

At MD Wellness, we understand that sometimes true emergencies arise that require last minute changes to your schedule. True emergencies will not be subject to the aforementioned fees.

Our services are very scarce and valuable. We strive to treat every person with great care, compassion and respect. We expect our patients to reciprocate by treating us the same way.

I _____ fully understand and agree with the cancellation policy.

Sign _____

Date ____/____/____

Credit/Debit Card Authorization Form

I _____ hereby authorize **MD Wellness and MD Skin** to charge \$ _____ to my Credit Card(s) listed below for consultations, "late cancellation" and "no show" fees. This authorization will remain on file until I cancel this authorization in writing.

Name: _____
(Please Print)

Address: _____
(Please Print) Street City State Zip

Home phone: _____ Cell: _____

Credit card Information

Name: _____
(Please Print – As shown in the Card)

Billing Address: _____
(Please Print) Street City State Zip

Credit Card Type: Visa Master Amex Discover Other: _____

Credit Card Number: _____

Expiration Date: ____/____ Security Code (CID): ____ ____ ____

MD Wellness Return and Exchange Policy

Products and supplements must be in an unopened package.

Returns must be done within 30 days of the purchase date.

Liquid supplements are non-refundable.

Shipping and Handling fees are non-refundable.

There is a 10% restocking fee taken from the price of the return. Air purifying products require 15% restocking fee.

All returns are subject to exemptions and evaluation by management

Signature

Date