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Patient Information Form

Chief Complaint (reason for being seen)	
I am interested becoming certified for Medical Marijuana: YES ___ NO ___	
Patient	Responsible Party
Name	Name
Mailing Address	Mailing address
Phone Number: Hm: Cell:	Phone Number: Hm: Cell:
Employer Work Phone	Employer Work Phone
DOB Gender SSN	DOB Gender SSN
Primary Ins	Subscriber Name
Group/Policy #	Relationship to Patient
Secondary Ins	Subscriber Name
Group/Policy #	Relationship to Patient
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Race:	
<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown/Refused	
Ethnicity: <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non-Latino/Non-Hispanic <input type="checkbox"/> Unknown/Refused	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Gujarati <input type="checkbox"/> Hindi <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Persian <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Urdu <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	
Patient information form vs. 1.17.18	

Who May We Contact in Case of Emergency

Name	Patient Relationship to Contact?	Primary Phone Number	Secondary Phone Number

PATIENT'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

NOTICE OF NOT ACCEPTING WORKER'S COMPENSATION AND NO-FAUL INSURANCE I hereby state that my condition is not covered under a Worker's Compensation or No-Fault insurance plan, and understand that Gomez Neurology does not accept such plans as payment.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS I hereby authorize and direct payment of my medical benefits to Gomez Neurology on my behalf for any service furnished to me by the providers.

Signature _____ Date _____

**Obtaining Verbal/Written Permission to
Use or Disclose Protected Health Information**

From time to time Gomez Neurology may need to collect or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by the Title 45, Section 164.10, we are permitted to make such uses or disclosures after we have obtained your verbal or written permission.

Gomez Neurology is authorized to: (please check all that apply)

Collect Protected Health Information from:

Practice Name _____ Date of Birth _____

Practice Address _____

Practice phone _____ Fax _____

Notify or speak regarding treatment or proposed treatment with

(please specify name): _____

(please specify name): _____

Other (please specify): _____

Name of Patient

Signature of Patient

Email address

Date

How may we contact you with reference to your appointments, proposed treatment, follow-up appointments, billing questions/problems, surgery scheduling, lab testing, radiology, and other situations regarding your protected health information?

HIPAA-compliant email permission Statement

I authorize Gomez Neurology its providers and employees to leave detailed messages specific to my medical care, including test results, through HIPAA-Compliant email at the email address listed below.

I understand that this authorization can be revoked at any time by submitting a written request to Gomez Neurology. This authorization is not required to receive care at Gomez Neurology. Patients opting not to sign this authorization will receive medical information such as test results through the phone or USPS mail rather than a voice messaging system or email.

Name of Patient Signature of Patient

Email address

Date

Voicemail Permission Statement

I authorize Gomez Neurology its providers and employees to leave detailed messages specific to my medical care, including test results, on the telephone number listed below. I understand that when a voicemail message exists, it is no longer covered under the Health Insurance Portability and Accountability Act of 1996 and therefore is not protected from unauthorized access.

I understand that this authorization can be revoked at any time by submitting a written request to Gomez Neurology. This authorization is not required to receive care at Gomez Neurology. Patients opting not to sign this authorization will receive medical information such as test results through the phone or USPS mail rather than a voice messaging system or email.

Name of Patient Signature of Patient

Email address

Date

Medical Marijuana

Thank you for your interest in New York State's Medical Marijuana program. Below you will find some answers regarding the program.

Dr Gomez is certified with New York State to recommend and certify patients for the Medical Marijuana program who meet the state's criteria. To be certified in the Medical Marijuana program, patients must have one of the following conditions: cancer, amyotrophic lateral sclerosis (ALS), Parkinson's disease, multiplesclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathy, PTSD, or Huntington's disease associated with severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms, or chronic pain.

Marijuana-related visits are solely for the purpose of certifying medical marijuana in the state of New York, and is not for the purpose of treating any conditions except through medical marijuana.

Gomez Neurology's medical marijuana visits are “cash only” and we do not accept any insurances for its certification. If you wish to be seen for your neurological problem, please call the office at 518-650-2090 for details.

The process of making an appointment

Dr Gomez requires copies of your last two medical visits (dated in the last 12 months), showing your exact diagnosis before you can be considered for the program.

Medical records may be faxed to our office at (888) 698-2021 or emailed to us at BizOffice@Gomezneurology.com. **DO NOT MAIL IN YOUR MEDICAL RECORDS, AS THEY WILL BE DESTROYED UNREAD.**

If you prefer, you can complete a Release Of Information form which is attached to this email. This completed form gives us permission to seek these records from your specified physicians for you.

Once we have received your medical records and they've been reviewed and it appears that you would be a good candidate for the medical marijuana program, our office will call to schedule an appointment.

Medical marijuana-related office visit costs:

There are two payment plans you can choose from. The first, is a total of \$275: \$100 (non refundable) upon scheduling your appointment, and the remaining \$175 at the initial appointment.

Or, if you prefer, there is a payment plan. Please contact your scheduler at Gomez Neurology for further details.

Payment methods include cash or credit card.

Yearly re-certification visit is \$70.

Medical Marijuana FAQ

What forms medical marijuana are allowed?

The Commissioner currently approved forms include liquids and oil for vaporization via inhaler, oral spray, inhaler, tincture and capsules to take orally. Under the law, smoking and edibles are not permitted.

Do I have to pay the state to register as a patient or as a caregiver?

Yes, there is a non-refundable application fee of fifty dollars (\$50) that will be billed to you at a later date.

When can I expect my registry identification card to arrive?

Once your application to register has been submitted successfully and approved, please allow approximately 3-5 business days to receive your Patient or Caregiver Registry Identification Card via mail. Once you have received your registry ID card you may visit a registered organization's dispensing facility to obtain medical marijuana products.

Which dispensing facilities may I use?

A certified patient may receive medical marijuana products from any dispensing facility of any Registered Organization in New York State.

Will every dispensing facility sell the same types of Medical Marijuana?

No. There are only two New York State-mandated products for Medical Marijuana (one with an equal ratio of THC to CBD, and one with a low-THC-high-CBD ratio) that must be offered by each Registered Organization. Each Registered Organization will also offer other products that have varying ratios of THC to CBD.

How much medical marijuana can be dispensed at a visit?

Registered Organizations may dispense up to a 30-day supply of medical marijuana to a certified patient or designated caregiver.

Can I use my out-of-state medical marijuana identification card to purchase medical marijuana in New York State? No. Only certified patients with a New York State registry identification card may purchase approved medical marijuana products in New York State.

How does the DOH ensure the quality of the products produced by the registered organizations?

The Department requires independent laboratory testing for every brand of product to be tested for any contaminants and to ensure product consistency.

Where will patients find the prices of Medical Marijuana?

Patients should contact the Registered Organization directly to obtain final prices, taking into account the dosing recommendations of their physician. The total amount that a patient pays depends upon a patient's individual dosing needs and the resultant total quantity purchased.

Important links from the New York State Medical Marijuana Program

About and News & Updates

www.health.ny.gov/regulations/medical_marijuana/about.htm

Frequently Asked Questions

www.health.ny.gov/regulations/medical_marijuana/faq.htm

Patient/Caregiver Information

www.health.ny.gov/regulations/medical_marijuana/patients/

Laws & Regulations

www.health.ny.gov/regulations/medical_marijuana/regulations.htm

Registered Organizations

www.health.ny.gov/regulations/medical_marijuana/application/

CONTACT GOMEZ NEUROLOGY AT

Call: 518-650-2090 ext 111

or reply to this email to send a HIPAA compliant reply.

Contact the New York State Medical Marijuana Program

Call: 866-811-7957

Email: mmp@health.ny.gov