Holistic Medicine & Skin & Body Services
1670 Route 34 N., suite 3B
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:

- ✓ Amyotrophic lateral sclerosis (ALS)
- ✓ Multiple sclerosis (MS)
- ✓ Chronic pain or weight loss from cancer
- ✓ Muscular dystrophy
- ✓ Inflammatory bowel disease, including Crohn's disease or ulcerative colitis
- ✓ Terminal illness, if the physician has determined a prognosis of less than 12 months of life.
- ✓ Seizure disorder
- ✓ Intractable skeletal muscular spasticity
- ✓ Glaucoma
- ✓ Positive status for human immunodeficiency virus (HIV)
- ✓ Acquired immune deficiency syndrome (AIDS)
- ✓ Post-Traumatic Stress Disorder (PTSD)
- ✓ Anxiety
- ✓ Chronic Migraines
- ✓ Chronic pain of visceral origin
- ✓ Chronic pain related to musculoskeletal disorders
- ✓ Tourette's Syndrome

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

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

The NJ MMP also requires the following documentation:

- Patient photograph (will be taken at the time of your visit).
- Proof of Identification (Current New Jersey Driver's License or Government Issued Photo ID).
- One utility bill or a letter from IRS or New Jersey State), issued in the past 90 days and must match your name on your proof of identity (water, electric, cable, internet, phone, sewer, cell phone

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. 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.

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

Fees and ID Cards:

Patients already diagnosed by another physician will be charged a $200 evaluation and processing fee. **Disabled veterans** will be charged a discounted fee of $100. MD Wellness will process your documents as part of our service to you. The state of New Jersey requires an additional fee of $100 for your ID card, which you will pay 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.

Quarterly Renewals:

After entering in the **NJMMP** system, you will be required to be evaluated by Dr Rothman every 90 days in order to keep your prescription valid. Phone consultations are available for this service. A $100 fee is requiring for your prescription renewals. Disabled veterans will get a discounted fee of $50 for renewals.

Government Assistance-if applicable:

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.

- NJ Medicaid Program
- Food Stamps Benefit
- 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

If you have not been previously diagnosed for your qualifying condition, the NJ MMP requires four visits before acceptance. Please call MD Wellness at **732-268-7663** for more information on medical treatments.

Your NJMMP 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.

Personal Information:

Your Name:	Last:	First:
DOB:	Month/Day/Year:	Age:
Driver License Number:		
Address:	Address:	City:
	Apt/Ste: County:	State/Zip:
Contact Number:		
Referral:		
E-Mail Address:		
Are you a veteran?	_____YES NO_____	
Are you on?	**PLEASE CHECK ONE OR ALL THAT APPLY**	
	____Medicaid (NJ Family Care) **____SSI** **____NJ Temporary Disability Benefits** **____Social Security Disability** **____Food stamps** **____TANF/General Assistance**	
Please Note: We are not contracted with any insurance companies, nor do we submit any claim forms.		

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 "Medigap 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.

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