Patient Advocacy Center 1443 W. Belmont Ave 332 Skokie Valley Road Phone: (312) 890-6113 info@thehealingclinic.org
Patient Packet Chicago, Illinois 60657 Highland Park, IL 60035 Fax: (844) 249-5580 http://thehealingclinic.org

The Healing Clinic

Dear Patient,

Thank you for your interest in The Healing Clinic! We appreciate your business.

The Healing Clinic LLC, is Chicago's leading patient advocacy center for providing patients who qualify, with a certification for a "Medical Cannabis Registration Card".
The Illinois Compassionate Use of Medical Cannabis Act, allows patients who have a "Qualifying Medical Condition" to seek certification by a licensed physician with who is also treating them. Under Illinois Law, registered cannabis patients can legally use, posses, and purchase medical cannabis from one of 60, state licensed dispensaries.

We are now accepting Blue Cross Blue Shield, United Healthcare, Aetna and Humana insurance plans. Unfortunately, our services are **not covered** by Medicaid or Medicare supplemented plans at this time.

Payment will be collected at the time of your visits. We require at least four office visits per year with your **THC-Integrative Primary Care Physician**, who will certify you to use medical cannabis. This is to maintain the state required bona fide patient/physician relationship. Your assigned **THC-Integrative Primary Care Physician** will submit a "Physician's Written Certification Form" to the Illinois Department of Public Health should they believe, after a thorough review of medical records related to your qualifying condition and conducting multiple in person physical exams, that you are a good candidate for medical cannabis. **Certification for medical cannabis occurs after your second doctor's visit.**
Renewal applications are required by the state every year. The Healing Clinic will gladly handle that process.

* *A fee of $150.00 is due at your first visit/Wellness Physical Examination*
* *A fee of $150.00 is due at your second visit/Integrative Care Plan + Cannabis Certification*

Cancellation Policy: There will be a $50 charge for appointments cancelled within 24 hours of your scheduled visit.

We accept Visa, Discover, Mastercard, American Express, and Cash Payments.

Please note that there are additional fees associated with medical cannabis registration. Ask one of our advocates or visit MCPP.illinois.gov for more information on the state's application requirements.

Again, we appreciate you choosing The Healing Clinic for your integrative medical needs. If you have further questions, please call or write to us! We are always here for you and happy to help.
The Healing Clinic, LLC
312-890-6113

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THC Patient Packet

Instructions for Patient Packet:

- Fill out and sign the **Authorization For Release of Health Information** form and send back to us as soon as possible. We will request the necessary records on your behalf. You may also submit it to the facility or provider that is currently treating your debilitating condition:
  The Healing Clinic
  Records Department
  Fax: 1-844-249-5580

  E-mail: info@thehealingclinic.org

- Records **must be current**, meaning from within the past year. **We only accept qualifying patients who have been diagnosed or treated for their debilitating condition(s) within the past 12 months.**
- Fill out the **New Patient Information** form completely and accurately either by hand or by downloading the document, saving it as a PDF file to *your computer*, and filling in the form fields. You may submit these forms as an email attachment to info@thehealingclinic.org.
- Please read and review our **Client HIPAA Rights** form carefully and please keep a copy for your personal records.

What to bring to your first appointment

- Make sure you have your government issued ID and TWO of the following documents:
  - Pay stub or electronic deposit receipt issued less than 60 days prior to the date of application that shows evidence of the applicant's withholding for state income tax.
  - Valid voter registration card with an address in Illinois.
  - Bank statement, dated less than 60 days prior to application.
  - Deed/title, mortgage, rental/lease agreement.
  - Insurance policy (homeowner's or renter's).
  - Medical claim or statement of benefits (from private insurance company or government agency), dated less than 90 days prior to application; Social Security Disability Insurance Statement; or Supplemental Security Income Benefits Statement.
  - Tuition invoice/official mail from college or university, dated less than 12 months prior to application.
  - Utility bill issued less than 60 days prior to application.
- Veterans and those on SSDI must bring appropriate documentation in order to receive a discount on both their appointment and state application fees.
  - Veteran DD214 or SSDI Benefits Verification Letter

***Be prepared to take a photo that will be used for your Illinois Medical Cannabis Registry Identification Card.**

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The person named above is or has been a patient of

Name of Provider or Facility _____

Address _____

Phone _____

Fax _____

Medical Records Released By:

_____
Name of Person, Provider, or Facility (Patients: Please leave this field blank)

Purpose or need for information:

Medical Records Released To:

The Healing Clinic
1443 W Belmont Ave
Chicago, IL, 60657
For the purpose of providing care for patient.
THC Medical Records Department Fax: 1-844-249-5580 (preferred method to receive PHI)

Email: info@thehealingclinic.org

Scope

☐ All information regarding assessment, diagnosis and treatment of patient's condition(s) or disease(es) listed:_____

☐ All information regarding care received by patient between the dates of _____ Starting Date and Present Time / Ending Date

Authorization

_____
Printed name of Patient or Authorized Representative

Unless revoked, this authorization will expire 30 days from date of signature. Patient has the right to revoke this authorization at any time.

_____ Signature of Patient or Authorized Representative _____ Date _____ Parent/Guardian of Minor Child _____ Date

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Federal regulations prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient.

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

HIV Status or Treatment

Drug and/or Alcohol Abuse Treatment

Mental Health Diagnosis & Treatment

Driver's License No.		Date of Birth	
Referred by		Gender	

Details of Debilitating Condition, including diagnosis date, location and other details
Details of any treatment already administered

Patient Information				
Name		SS Number		
Address				
City		State		ZIP
Mobile Phone		Home phone		Work Phone
Email				

I give The Healing Clinic consent to use my information listed above to complete the online IDPH application on my behalf:

Print Name_____ Signature_____ Date_____

Instructions	
☐	Pre-visit instructions and directions provided
☐	Applicable records and reports acquired
☐	Appointment date and time confirmed

The Healing Clinic

Patient Health History Past Diagnoses or Treatment of:			
	Acquired Immunodeficiency Syndrome (AIDS)		Lupus
	Agitation of Alzheimer's disease		Multiple Sclerosis
	Amyotrophic Lateral Sclerosis (ALS)		Muscular dystrophy
	Arnold-Chiari malformation and Syringomelia		Myasthenia Gravis
	Cachexia/wasting syndrome		Myoclonus
	Cancer		Nail-patella syndrome
	Causalgia		Neurofibromatosis
	Chronic Inflammatory Demyelinating Polyneuropathy		Parkinson's disease
	Crohn's disease		Post-concussion syndrome
	CRPS (Complex Regional Pain Syndromes Type II)		RSD (Complex Regional Pain Syndromes Type I)
	Dystonia		Residual limb pain
	Fibromyalgia (severe)		Rheumatoid arthritis (RA)
	Fibrous dysplasia		Seizures, including those characteristic of epilepsy (Starting January 1, 2015)
	Glaucoma		Sjogren's syndrome
	Hepatitis C		Spinal cord disease, including, but not limited to, arachnoiditis, Tarlov cysts, hydromyelia,
	Human Immunodeficiency Virus (HIV)		Spinal cord injury
	Hydrocephalus		Spinocerebellar Ataxia (SCA)
	Interstitial Cystitis		Tourette’s syndrome
			Traumatic brain injury (TBI)

List of all surgeries and hospitalizations including date occurred:

List of all prescription medicines and nutrient supplements/herbs including dosage:

Sleep

Hours per night ___Wake refreshed ☐ Y ☐ N Must nap during day ☐ Y ☐ N Nightmares ☐ Y ☐ N

Social Life

Enjoy Job ☐ Y ☐ N

Hobbies:

Greatest Health Concerns

Send your completed patient packet either by fax or as an email attachment to
The Healing Clinic ATT: Records Department
Email: info@thehealingclinic.org | Fax: 1-844-249-5580

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We respect patient/client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by The Healing Clinic LLC.

Use and disclosure of protected health information

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our clinic. This includes for:

Treatment. We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our Agency that we are consulting with or referring you to.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

*Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

*Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health---related benefits and services that may be of interest to you. We will leave appointment information on your voice mail or leave an email or text message unless you tell us not to.

*As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

*Coroners. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

*Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. We are also required to share information, if requested with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our services or for coordination of your care.

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CLIENT HIPAA RIGHTS

You have the following rights under Illinois and Federal Law

Copy of Record. You are entitled to inspect the client record our Agency has generated about you.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization. Except as described in this Notice or as required by Illinois or Federal law, we cannot release your protected health information without your written consent.

Restriction on Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. The Agency is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We also will be glad to provide you information by email if you request it.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Notification of Breach. You have a right to be notified if there is a breach of your protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of the HIPAA Privacy Rule if there is an assessment that your protected information may be compromised.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact us in writing, by phone or in person. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe our Agency has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. The Healing Clinic LLC reserves the right to change its PrivacyPolicy based on the needs of the Agency and changes in state and federal law. U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our services or for coordination of your care.