Releaf Cannabis Clinic, LLC

(346) 433-1579 phone
(832) 344-3000

Our Office

You can reach the office staff or provider by email, phone call or text for non-emergent requests. If you need to schedule an appointment, request a prescription refill or test results, please contact us during our posted business hours or send a request through one of the options above.

New Patients

First time patients are asked to log into the telemedicine appointment at least 15 minutes early to allow adequate time for any technical issues that may arise. For purposes of maintaining continuity of care, we ask that you provide us with the latest relevant information.

Courtesy

We strive to provide the best care for our patients. While we make every effort to provide prompt on-time service, the needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience. If you have any suggestions or complaints for our office, please let us know. Our staff understands that it is expected to display courteous and respectful actions toward all patients, we kindly ask that it is reciprocated from our patients as well.

Driver's License / Insurance ID / Social Security Number

Releaf CC requires that all patients seen and treated must provide a copy of legal identification, i.e. state driver's license, Insurance ID, state ID, passport, or military ID. A copy will be made and placed in the patient's HIPPA protected medical record (chart). However, it may be requested at any subsequent visit to the office.

Your social security number is required by state agencies. Patients under the age of 18 may be required to provide their birth certificate as identification and the parent or legal guardian will also attest to their identity.

Prescription Refills and Pharmacy Information

We will provide 6 months of your medications at your appointment time. Refill requests require a new appointment.

Forms / Letters

We understand that at times, various forms or letters may be required to assist you with your healthcare or employment needs. We are happy to complete forms and write medical letters as necessary upon your request. There is a charge per form depending on the complexity. Minimal charge is $25, may be up to $50 max. Please allow 5 business days for completion of requested forms/letters.

No Show-Late Cancellation Policy

There is a $50.00 no show/late cancellation fee. All appointments must be canceled 24 - 48 hours before the appointment date to avoid charges for no show or late cancellation. After hour messages regarding cancellations may be left at the telephone number/text provided above. In your voicemail or text, please provide your name, date of birth, and time of call. If you are running more than 15 minutes late to your scheduled appointment, please call or text us to reschedule your appointment. Late cancellation fee may apply. If you believe we have made an error in scheduling or you believe you deserve special consideration, please call us and ask to speak to the office manager.

HIPAA Notice of Privacy Practices

Releaf CC is required to abide by the Notice of Privacy Practices and we respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices, therefore, please review our Notice of Privacy Practices. This Notice describes how we protect your health information and what rights you have regarding it. A written copy of this document will always be available to our patients by request.

Notice of Privacy Practices Summary

Effective April 14, 2003

In 1996 Congress passed the Health Insurance Portability and Accountability Act. Included in this act is “The Privacy Act" which was approved August 14th 2002. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully. Who will follow this notice? This notice describes our practices and that of: Any health care professional authorized to enter information into your chart. All departments and units of each health care provider listed below. Any member of a volunteer group we allowed to help you while you are a patient of Releaf Cannabis Clinic, LLC. All employees, staff and other personnel of Releaf Cannabis Clinic, LLC. All medical clinics and other Healthcare Providers owned and/or operated by a legal entity owned or controlled by Releaf Cannabis Clinic, LLC. The entities, sites and locations listed above are treated as a single affiliated covered entity, are referred to in this notice as “Releaf Cannabis Clinic” and follow the terms of this notice. These entities, sites and locations may share medical information with each other for treatment, payment or health care purposes and as otherwise allowed by Texas and federal law.

Duties of Releaf Cannabis Clinic, LLC

We are required by law to:

Maintain the privacy of protected health information

Provide patients with notice of its legal duties and privacy practices

Abide by the terms of the notice of privacy practices currently in effect

Prominently display and make available Notice of Privacy Practices.

We reserve the right to change the terms of its Notice of Privacy Practices as directed by HIPAA and to make the new notice provisions effective for all protected health information that it maintains.

Releaf CC Permitted Uses and Disclosures of your Protected Health Information

We may use and disclose information about you (e.g. name, address, social security number) and your medical condition(s), including past, present and future, for the following purposes:

Treatment: such as disclosed information to a specialist, hospital, laboratory or pathologist to evaluate and address your medical needs (including amended information).

Healthcare operations: information disclosed to evaluate and maintain the functions of Releaf CC (e.g. the quality of care it provides or to perform business analysis)

Releaf CC may use your protected health information to contact you regarding:

Appointment reminders

Lab and x-ray results

Information about treatment alternatives

Other health-related benefits and services that may be of interest to you

We may also use and disclose your Protected Health Information without further consent from you in the following circumstances:

Public Health Agencies: For the purpose of reporting disease, Vital Statistics, or adverse effects from drugs, supplies or equipment.

Serious threats to Health/Safety: In cases of medical emergencies or instances where imminent and serious health or where safety threats exist.

Deceased Patients: To coroners, medical examiners, funeral directors and organ donor officials.

Law enforcement: To law or military officials for the purpose of health delivery oversight, judicial or administrative proceedings, law enforcement and National Security.

Required by law: To State officials for the purpose of management and financial audits, program monitoring and evaluation, licensure and certification.

HealthCare Oversight: To the Department of Health and Human Services for purposes of compliance investigations and reviews.

Research: To researchers when their research has been approved by the Institutional Review Board who reviews research proposals and establishes protocols to ensure the privacy of protected health information.

Worker's Compensation: To Employers as required by Texas Workers Compensation Laws in case of a work-related injury.

Victims of abuse, neglect or Domestic Violence: May be required to disclose medical information if there is evidence of abuse or neglect to appropriate enforcement agencies.

Individuals involved in your care or payment for your care: To a friend or family member who was involved in your medical care.

Military or Veterans: To a member of the Armed Forces as required by military command authorities.

Lawsuits and disputes: To a court or administrative representative regarding a lawsuit or dispute.

Non-routine Uses and Disclosures: Those uses and disclosures which exclude treatment, payment and Healthcare purposes will be made ONLY with your written authorization of which you may revoke at any time.

Patient Responsibilities:

The patient has the responsibility to provide the physician with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, allergies and unexpected changes in the patient's condition. The patient is responsible for asking questions when they do not understand what they are told or what they are expected to do. If the plan of care is agreed upon, the patient has the responsibility to follow the plan of care or express concerns with compliance.

The patient and family are responsible for following the pre and post procedure care plan.
The patient and family are responsible for the outcomes if they do not follow the plan of care.

The patient and family are responsible for promptly meeting any financial obligation agreed to with the practice.

Patient-Physician/Office Staff Communication

Releaf CC requires our staff to obtain prior authorization to leave a detailed message/information via text, email, or voicemail for the patient. This policy is in accordance with HIPAA regulations concerning protecting the patient's confidentiality. Please review the "Communication Consent" section below.

COMMUNICATION CONSENT

I hereby authorize the staff to call and leave their name, the doctor's name, and additional information on an answering machine, email, text, or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Releaf providers and/or staff to leave a message regarding treatment, test results and other necessary information.

1) On the answering machine at my home number provided

2) On voicemail at my cell phone number provided

3) By text on at my cell phone number provided

4) By email at my email address provided

5) By text via Telemedicine app

IF YOU DO NOT CONSENT TO ABOVE "COMMUNICATION CONSENT" PLEASE INDICATE SO BY

SENDING A OPT OUT EMAIL TO US AT contact@releafcannabisclinic.com

I DO NOT Consent to any messages being left on an answering machine, voicemail, text, or email other than the caller's name and phone number asking me to call, email or text back.

Medical Records

Per HIPAA guidelines, copies of medical records must be requested in writing. Please do so by completing the “Authorization For Release Of Medical Record Information” form that is available on our website. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials.

The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner. There is a $50 charge dependent on the quantity of records, for patients who request copies of their medical records for personal use. This fee covers copies, processing and handling up to 25 pages.

Medical records that will be faxed, mailed, or electronically submitted to another provider’s office for continuity of care will be free of charge.

Authorization for Release of Information to Family Members/Friends

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical or billing information released to family members you must provide consent. Send in a written form to allow us to give information to family members/friends.

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I authorize Releaf Cannabis Clinic, LLC to release my medical and/or billing information to the individual(s) I’ve identified as my emergency contact on my profile.

Financial Responsibility

I have requested medical services from Releaf CC on behalf of myself and/or my dependents, and understand that by making this request, I am financially responsible for any and all charges incurred in the course of treatment. All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office.

Payment for Services

Our practice accepts debit and credit cards, Zelle and Venmo payments only. American Express is not accepted. Insurance is NOT accepted. Each office visit and procedure accrues its own service fee.

Financial Lawsuit and/or Dispute

I hereby authorize Releaf CC LLC to release my Protected Health Information if one of the following should occur:

a) A dispute is filed with a financial institute b) Fraud is suspected c) A court order and/or subpoena is received.

Insurance Coverage

Our services are NOT covered by insurance.

PATIENT PHOTOGRAPH & VIDEO AUTHORIZATION AND RELEASE

I authorize Releaf CC providers and representative(s) to take photographs, slides, audio and/or video recordings of me for the following:

In office chart,

For in office seminars and staff training purposes

On our website(s) as testimonial

In print advertisements/marketing

On television/radio

On social media websites/apps (ex: Facebook, Instagram, Twitter, Snapchat, Youtube, LinkedIn etc)

I understand that:

- Such images and/or video recordings may be used without compensation to me

- Such images and/or video recordings may be published by Releaf CC in any print, visual and/or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet websites and/or media apps, for the purpose of informing the medical profession or the general public about Releaf CC protocols and results.

- Such uses of these images and/or video recordings may also include marketing on behalf of

Releaf CC, for which we may receive direct or indirect remuneration.

- I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the images or video recordings may display features that identify me.

- I have the right to revoke this authorization in writing at any time and if I decide to do so I must present my written revocation to Releaf CC LLC, via email to contact@releafcannabisclinic.com revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.

- I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Releaf CC.

- The information disclosed under this authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be

protected by applicable federal and/or state confidentiality rules.

- A copy of this authorization is valid as the original. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Releaf Cannabis Clinic LLC, its providers and its representative(s) from all liability, including liability for negligence that in any way arises.

CONSENT FOR TREATMENT

I authorize and direct Releaf Cannabis Clinic LLC, its providers/mid-level providers (nurse practitioner/physician assistant)/assistants to perform quality care, including, but not limited to: diagnostic procedures, consultations and second opinion as may be necessary in their professional judgment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any consultation.

Telehealth/Telemedicine

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. I understand that I will be given information about the test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit. I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information. As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective

interaction between consulting clinician(s), participant, patient or care team. I hereby release and hold harmless [NAME] and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

Grievances or Concerns

Please be advised that if you have a grievance or concern you may call the respective medical licensing board. If you have suggestions for us, please place this in writing and email to the office. We will do our best to address your concern promptly.

AGREEMENT AND UNDERSTANDING

I have read, fully understand, and agree to abide by the above disclosures, general and financial policies.

I understand that a copy of this document is available on our website and that I may request a copy for my records.

I have read the Notice of Privacy Practices for Releaf Cannabis Clinic, LLC.

I have read, fully understood and agreed to the Patient Photograph, Audio & Video Authorization and Release.

I have read and understood the Patient responsibilities.

I have read and understand the Consent For Treatment & Grievance process.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understood the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understood the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

_____

Printed Name of Patient or Patient's Legal Representative/ Relationship to Patient

_____

Signature of Patient or Patient's Legal Representative **Date and Time**

INTERPRETER'S ATTESTATION (if applicable): I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

_____

Printed Name of Interpreter

_____

Signature of Interpreter **Date and Time**