# The Healing Joint

**Jeannette Musset, NMD**

## Medical Service Agreement for Medical Cannabis

I, ____________________________________ , have been diagnosed by a Licensed physician in the state of Arizona as having a qualifying condition for the use of medical cannabis, covered under current Washington State law.

_____ (Initials) Dr. Musset will assess my medical history and condition and if it is in his/her opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks I will abide by the rules and regulations pertaining to being in the state of Arizona Medical Cannabis patient.

_____ (Initials) I agree that Dr. Musset has a good faith belief that the conditions described on my medical intake form are legal under the current laws of Arizona State and do qualify me, to the best of my understanding, for medical cannabis in Arizona. I also understand that I may or may not have a medical necessity defense to federal prosecution under federal law. I am willing to testify before law enforcement authorities that my conditions are true and correct to the best of my knowledge.

I,____________________________________ , release and hold harmless the healing joint, Dr. Musset and its medical professionals and staff of any liabilities regarding the sharing of medical information of above named patient and will only provide medical records/medical evaluation information by written request at 2334 N Scottsdale Rd Suite A 130, Scottsdale AZ 85257. Dr. Musset will be willing to verify that the above patient has gone through our clinic and has a medical cannabis authorization with us by phone. Healing joint, Dr. Musset and its medical professionals and staff, does not accept or agree to provide medical and/or legal testimony.

______ (Initials) In accordance with Arizona law regarding becoming a medical cannabis patient, I acknowledge I have attempted/consulted other methods of conventional treatments/diagnosis prior to the use of cannabis; I have been informed of other methods of treatment besides cannabis for my qualifying medical condition; I agree to follow up with Dr. Musset to monitor the progress of my qualifying condition (to evaluate the effectiveness of this treatment) through an ongoing treatment plan.

By signing below I agree that all my information is correct and that I have read the above statements.

Print Name ________________________________________________

DOB :_________________

Signature _________________________________________________ Today's Date _____________