Member Contact Information

The member's right to privacy and confidentiality shall extend to all records pertaining to the member's treatment except as otherwise provided by law. Summit Medical Compassion center believes that understanding and adhering to the federal HIPAA standards will ensure that we are meeting our privacy obligations to our members.

*Date: ______________________

*First Name: ___________________________*Last Name: __________________________________

Preferred first name (if different): ______________________________________

Current Address: ____

Apt/PO#:_______________ City:__________________________ Zip Code:_____________________

Phone #: _____________________________________ State: ___________________

If we do call, may we leave a message? Yes No

*Emergency Contact: __________________________ *Relationship: __________________________

*Emergency Contact Phone #: ____

How did you hear about Summit? __________________________________

Preferred Rates Program Member Agreement

I, ____, am currently eligible for and/or receiving Rite Care, Food Supplement Benefits, Supplemental Security Income, Medicare, Social Security Disability Income; or, I am a military veteran or age 65 or over.I give Summit Medical Compassion Center the permission to verify my current eligibility with my Family Independence Specialist or case worker at DOH as Summit Medical Compassion Center deems necessary.

I have provided the original of the documents(s) selected below for Summit Medical Compassion Center to copy for their records. I understand that my records are kept confidential by Summit Medical Compassion Center to the extent possible under existing state statutes:

- ☐ Eligibility for Rite Care
- ☐ Eligibility for State Food Supplement Benefits (EBT)
- ☐ Eligibility for Supplemental Security Income (SSI)
- ☐ Eligibility for Medicare
- ☐ Eligibility for Social Security Disability Income (SSDI)
- ☐ Proof of Military Service
- ☐ Proof of Being 65 Years or Older

I will notify Summit Medical Compassion Center and provide updated documentation if my eligibility for or status in the above-selected program(s) has been changed, renewed, or discontinued.

I understand that this Preferred Rates program may be altered or discontinued by Summit Medical Compassion Center at any time, with or without notice.

Member Signature ____ Date ___________

Witness Signature ____ Date ___________

Summit Medical Compassion Center

Member Conduct Agreement

Thank you for choosing Summit Medical Compassion Center as your medical cannabis dispensary. Our staff looks forward to working with you to support your overall health and well-being.

In order to build a strong community with our clients and our neighbors, each member who registers with us is required to agree to a code of conduct before we can serve them. **Please read the list below and initial next to each item** to show you have understood and agreed to these rules.

___ Diversion of medicine (selling it to another, whether or not they are a patient) is strictly prohibited. Diversion is illegal, and places Rhode Island's medical marijuana program, and all patients, at risk. SMCC has a zero-tolerance policy for any behavior that suggests that diversion MAY be happening. We are required to report suspected illegal behavior to the Department of Health and to local law enforcement. SMCC will terminate the membership of any client who engages in behavior that indicates diversion may be happening, and we will report all suspicious behavior to the appropriate authorities.

___ You **must show your valid Medical Marijuana Card** AND a **valid State Driver's License/ID (No Phone Copy)** each time you visit us. Caregivers/ Authorized Purchasers must bring both their own documents and their patient's MMJ card at the first visit. (**Out of State caregivers are not allowed)**

___ We share our parking lot with our neighbors. Please drive slowly in the lot and keep music levels down. Never use or display your medicine in the parking lot or in your vehicle.

___ State law **prohibits children under the age of 18** and other persons who are not patients or caregivers, from accessing the facility. Please arrange for child care when you visit.

___ Service animals are welcome here. Service animals should wear an identifying tag or garment and must be on a leash during their visit. We use the "four on the floor" rule at all times--no paws on the furniture, please!

___ Tobacco smoking is permitted outdoors at least 20 feet from doors, windows or vents. Please do not litter-use the ash receptacle provided.

___ In the interest of member confidentiality, **cell phone** and **camera** use in the dispensary is **strictly prohibited**. If the member needs to use their phone, they are expected to do so outside the dispensary.

___ Treat other patients, our staff, our neighbors, and our facility with respect at all times.

___ **All medicine is non-refundable**. Please make sure your purchase is correct before you cash out/leave the dispensary.

I have read and understood the Member Conduct Agreement. I understand that my membership privileges may be reduced or revoked if I fail to conduct myself in accordance with this agreement.

Member Signature ________________________________ Date __________________

Caretaker Signature ________________________________ Date __________________

Staff Signature ________________________________ Date __________________