ALDRIDGE MEDICAL CARE Services and Fees

We reserve the right to change fees without notice.

Select all services desired.	**Fees**

□ Doctor Evaluation and Letter of Recommendation Doctor's exam and letter of recommendation is required by law. You may grow up to 12 plants.	Renewal	□ $50
□ Medical Marijuana ID Card (optional) Free with Full Protection (see below)		□ $10

□ Full Protection Services (optional): Choose Level 1, 2 or 3		
□ Level 1 Basic Services	Includes 2 letters of recommendation, free ID and insurance cards, free document replacement, and, upon request, free doctor's letter for court, Caregiver's Certificate, medical records, and other legal documents free of charge. Doctor's court appearance fee waived if courthouse is within 100 miles of our office.	□ $25
□ Level 2 General SB 420	Includes all basic services, plus a general SB 420 Exemption, allowing you to grow and possess more medical marijuana than State Bill 420 normally permits. See back of page for more details.	□ $50
□ Level 3 Grower's Choice	Includes all basic services, plus a specific SB 420 Exemption, allowing you to grow a specific number of plants up to 99, and possess a specific amount of dry marijuana up to 6 pounds. See back of page for more details.	□ $100

□ Letter for court, and other legal documents	□ $30
□ Replacement Letter Of Recommendation	□ $25
□ Medical Record Copies	□ $15
□ Other_____	□ ____

Total Fee:	

_____ _____

Name (please print) Signature Date

ALDRIDGE MEDICAL CARE PATIENT FOLLOW-UP ASSESSMENT AND TREATMENT PLAN

Patient Information
(Please print)

Name (first, middle, last) _____ Gender: M F

Age _____ Date of birth _____ Weight _____ Height _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Has your medical condition changed since your last evaluation with us? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____
_____
_____

Have you had any problems or adverse side effects with marijuana / cannabis? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____
_____

_____ _____
Patient's Signature Date

OFFICE STAFF USE ONLY BELOW THIS LINE

Vital Signs: BP _____ Pulse _____ Temp _____ Respirations ____ Weight _____

_____
_____
_____
_____
_____
_____
_____

Assessment and Plan: ☐ Unchanged from previous evaluation ☐ Other:

_____
_____
_____
_____
_____
_____

_____ _____
Doctor's Signature Date