



I, _____ (patient name), hereby agree to the following payment which is due at the time of the visit to Maryland Cannabis Physicians, LLC on _____ (date). I understand that there are no refunds/credits/reimbursements of payment. Payment does not mean that I will receive a cannabis card in the state of Maryland, which will be determined by the Maryland Commission.

Maryland Cannabis Physicians Cost Sheet:

_____ Initial medical cannabis evaluation- \$200.00

_____ Renewal of cannabis card for established patient- \$150.00

Additional Fees:

_____ Urgent medical cannabis evaluation (within 24 hrs)- \$100.00

_____ Medical record retrieval- \$30.00

_____ Diagnosis of medical condition- \$100.00

_____ Total amount to be paid to Maryland Cannabis Physicians, LLC at time of visit. Maryland Cannabis Physicians, LLC will only accept cash, there are no exceptions.

Patient Signature _____ Date _____