NATUROPATHIC INFORMED CONSENT

Every patient is required to read and sign this form before your first treatment and this form will apply to naturopathic treatments at both Whole Medicine clinic locations. Your signature acknowledges the following: Naturopathic medicine is the use of gentle, non-invasive treatments and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Your licensed Naturopathic Doctor at Whole Medicine will take a thorough case history, perform a physical exam and may suggest specific diagnostic testing in addition to treatment recommendations.

It is very important that you inform your Naturopathic Doctor immediately of any diagnoses that you have received from other licensed health care providers and any prescribed or over the counter medications that you are currently taking. Please also advise your Naturopathic Doctor if you are pregnant, suspect you are pregnant or if you are breast-feeding.

There are some minor health risks that may be associated with naturopathic treatments. These include but are not limited to:

- Some patients may experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies that you may have
- Pain, bruising or injury from venipuncture or acupuncture or parenteral therapies, or cupping.
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

I understand:

- The clinic does not guarantee results, as with all medical therapies, naturopathic medicine has its limitations and may not be able to treat all conditions
- That my Naturopathic Doctor will explain the nature of my treatment and will answer any questions that I may have
- I am free to withdraw my consent and to discontinue treatment at any time
- That naturopathic medicine can work in conjunction with other forms of therapy and need not be considered exclusively beneficial. I do not need to choose one form of treatment over the other.
- That expenses for Naturopathic Care are not covered under provincial health care. Naturopathic expenses may be tax deductible or covered by extended health care benefit plans. Please check with your insurance provider for coverage.
- Natural health care is a joint responsibility between myself (the patient) and my practitioner. Improving my lifestyle can be as important as the therapies and treatments provided by the clinic. I am willing to be an active participant in my wellness.
- My health records may be used in research providing that my name or any identifying information is not revealed. At all other times, my health records will be held in strictest confidence.
- That Naturopathic medicine is not an isolated system and that Dr. Kealy Mann, ND and Dr. Chelsey Corrigan, ND welcome teamwork with MDs, DCs and other practitioners.
- I understand that the decision to discontinue prescription medications or any other prescribed medical treatment is my own responsibility. If I forego standard medical treatment in favor of natural therapies, I assume responsibility for any potential risk that may entail. Dr. Corrigan, ND and Dr. Mann, ND will explain procedures, probably outcomes and possible risks whenever possible.

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Fees for services: Payment is due at the end of each visit. We accept payment by cash, debit, Mastercard or Visa.

New Patients Visits:	Initial visit -	50 minutes:	$170	($160 for children 16 & under and seniors 65 and over)
Follow Up Visits:	Second visit -	50 minutes:	$170	(reduced rates for children and seniors as above)
	Short follow up -	25 minutes:	$ 90	($85 for children and seniors)
	Brief follow up -	15 minutes:	$ 50	($45 for children and seniors)
	Acupuncture* -	25 minutes:	$ 70	40 minutes: $100 *requires Initial Visit

Cancellation Policy:

Two full Business Days' notice is required when cancelling your appointment, otherwise a fee will be billed (as per our Clinic Policies*) (*Clinic Policies emailed to you prior to your initial appointment, Signing this form indicates you have read and have agreed to our clinic policies and our cancellation fees.

Patient Name: (please print) ______________________________

Guardian Name (if applicable):______________________ Relation: ______________

Street Address: ______________________________

City: ______________ Province: ____________ Postal Code: ____________

Email Address: ______________________________
Would you like to receive our newsletter? Yes No

Phone: Home ( )______________________ Work: ( ) ______________________
Please put a * next to your preferred contact number

Date of Birth: MM/DD/YYYY ______________

Emergency Contact:______________ Relation: ____________ Phone: ____________

Family Physician: ______________________ Phone: ( ) ______________________

How did you hear about our clinic? (If referred, please give name) ______________________

Signature (Patient or Guardian): ______________________ Date: ______________

PRIVACY POLICY

Beginning January 1, 2004 the Canadian Federal Government's privacy legislation, the Personal Information Protection and Electronic Documents Act (the Act) came into force for private business. This office is committed to protecting your personal information in accordance with this Act.

In general, The Act requires that the office obtain your consent before obtaining or using information about you or disclosing this information to others (there are some exceptions). This requirement also applies to personal information that has already been collected about you before January 1, 2004. This notice explains why the office collects personal information from you, how it will be used and the steps being taken to ensure your privacy is protected.

What is personal information?

Personal information is information that identifies you as an individual. It includes information such as your name, address, telephone number, e-mail address, and date of birth, medical history and medical records.

What happens to my personal information?

All information collected by this office, remains in this office. Files are placed in a locked cabinet and can only be accessed by the practitioner and his/her personal staff. From time to time case histories are discussed between practitioners in an effort to provide the best possible course of action for our patients.

Our staff sign a 'Confidentiality Agreement' upon employment here. Staff may not discuss information outside of this practice. All information contained in the practice including telephone conversations, correspondence and files are privileged information and cannot be released, copied or discussed without the prior written consent of the client.

Staff are aware of personal identifying information only. They pull and file records as required.

I have read this notice and understand it contents.

I, ______________________________ (the undersigned) do hereby acknowledge that I have read and understood the above Privacy Policy and Consent of this office.

Signature: ______________________________________ Date: ___________________________________

CONSENT TO INFORM PRIMARY CARE PROVIDER OF PRESCRIPTION MEDICATIONS

Regulations for Naturopathic Doctors in the province of Ontario require that Naturopathic Doctors must provide notification to a patient's other primary health care providers when they have been prescribed a drug listed on Table 3 of the Ontario Regulation 168/15 made under the Naturopathy Act, 2007.

Examples of recommendations made by Dr. Mann ND and Dr. Corrigan ND that are classified as prescriptions include:

- Vitamin D greater than 1000IU daily, folic acid greater than 1mg daily
- Bio-Identical hormones such as estrogen and progesterone
- Thyroid hormone
- Any nutrient administered by injection or intravenously

Patients can refuse consent, with the understanding that they should inform all members of their medical team of all prescriptions.

Please note that if you check "no" below, at any time in your visit, you can verbally request that we send individual prescriptions to your MD.

I, ____ (Print First & Last name); request that

Please initial one below:

_____ YES, my Naturopathic prescriptions should be communicated regularly to my MD

_____ NO, my Naturopathic prescriptions should not be communicated regularly to my MD

____ ______________________

PATIENT SIGNATURE DATE

Please complete the following if communication is desired:

Primary Health Care Provider (Family Doctor): ____

Clinic Name: ____

Phone: ___________________________ Fax: _____________________________________