WHOLE MEDICINE FOOD SENSITIVITY TESTING
INFORMED CONSENT & PATIENT AGREEMENT

Name (please print): _____ Date: _____

Phone: home ( )_____ work ( ) _____

Address:_____ City: _____ Postal Code: _____

Date of Birth: _____ Email Address: _____

Emergency Contact: Name: _____ Phone: _____

How did you hear about our clinic (if referred, please provide name): _____

Every patient is required to read each section below before treatment. Your signature at the end of this form acknowledges the following:

1. General Medical Consent

As with all testing devices, electrodermal food and environmental testing has its limitations and may not be effective for all conditions. This testing does not diagnose health conditions and is different from a food allergy test. I am free to withdraw my consent and discontinue treatment at any time. The electrodermal device used to perform this test is not licensed by Health Canada. We recommend discussing the results of this test with a qualified practitioner to explore causes of food sensitivities and to prevent nutrient deficiencies and imbalances that may occur if not supervised by a qualified practitioner.

I realize that this test and natural health care is not an isolated system and that Whole Medicine's Practitioners welcome teamwork with MD's, DC's and other practitioners. I do not need to choose one method of treatment over the other. The decision to discontinue prescription drugs or any other prescribed medical treatment is my responsibility and should be done in consultation with my MD or prescribing physician.

Although there are no known side effects, due to limited research, this test should not be performed if: 1. You are pregnant 2. You have a pacemaker 3. You use an insulin pump*

I have read and agree to the General Medical Consent above: _____

Signature (Patient or Guardian)

2. Diagnostic Services Policy

This test is not performed by a Naturopathic Doctor and is therefore not covered by most health insurance plans. This test is not covered by OHIP.

I have read and agree to the Diagnostic Services Policy above: _____

Signature (Patient or Guardian)

Emergency Services Policy

Whole Medicine does not provide emergency services. In case of an emergency, please call 911 or visit your nearest emergency facility.

I have read and agree to the Emergency Services Policy above: _____

Signature (Patient or Guardian)

3. Fees and Payment Policy

Payments for Food Sensitivity Testing are NOT covered under the Ontario Health Insurance Plan (OHIP). The receipt you receive can be used to obtain reimbursement directly from your insurance company (if applicable). Whole Medicine is NOT responsible for your insurance claims or reimbursement. Payments for services are due at the end of each session. If there are any questions regarding payment of fees, please ask for further

information. We accept payment by cash, Interac, Mastercard or Visa. Interest will be charged on overdue accounts. Fees for services are as follows:

Adult Test (50 minutes): $150
Pediatric Test - Infant to 17 years of age (30-50 minutes): $140
Retesting (within 2 years) (50 minutes): $120
By the Item (Re-test only) - Base fee $70 + $1.75 per item after 40 items
Please note that refunds will not be issued for services rendered
** If you would like to have more items tested (which you will have to provide), please call to receive a quote and to book a longer appointment time to accommodate.

I have read and agree to the Fees and Payment Policy above: _____
Signature (Patient or Guardian)

Cancellation Policy

We require a MINIMUM of 48 hours (Saturday and Sunday excluded) notice for any appointment changes or cancellations to allow us time to reallocate the time slot to other patients / clients on our wait list. Therefore an appointment at 9am Tuesday must be cancelled by 9am Friday and an appointment at 12pm Monday must be cancelled by 12pm Thursday.

- Cancellations with only 24 hours notice will result in a $50 cancellation fee.
- Same day cancellations or missed/no-show appointments will result in a charge for the full amount of your appointment.
- Patients who arrive late for their appointment will have a consultation shortened by that amount of time, but will be charged the full scheduled visit fee

Due to the nature of changing WEATHER FORECASTS, please wait until the day of your appointment to call regarding bad weather.

I have read and agree to the Cancellation Policy above: _____
Signature (Patient or Guardian)

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?
We use a digital records management system that encrypts all medical data. Paper files are placed in a locked cabinet and/or room 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, but identifying information is kept private.

Our staff sign a 'Confidentiality Agreement' upon employment here. Staff may not discuss patient 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. My health records may be used in research providing that my name is not revealed. At all other times, my health records will be held in strictest confidence.

I have read and agree to the Private Policy above: _____
Signature (Patient or Guardian)