

CONTACT INFORMATION

Date: _____ Name: _____

Address: _____

City: _____ Postal Code: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____

Emergency Contact Name & Phone Number: _____

Name of Family Physician: _____

How did you hear about us? Internet Search Health Practitioner Referral
 Clinic Signs Brochure Friend/Family
 Other _____

Would you like to receive Dr. Andresen's monthly "Health Tips" newsletter by email? Yes No

CURRENT HEALTH CONCERNS	
PLEASE LIST YOUR CURRENT HEALTH CONCERNS <u>IN ORDER OF MOST IMPORTANCE</u> TO YOU:	
1.	5.
2.	6.
3.	7.
4.	8.

1.	5.
2.	6.
3.	7.
4.	8.

MEDICAL HISTORY

PLEASE LIST ALL ALLERGIES (FOOD, ENVIRONMENTAL, MEDICATIONS):

1.	4.
2.	5.
3.	6.

PLEASE LIST ALL CURRENT MEDICATIONS THAT YOU ARE TAKING, THE DAILY DOSE AND DURATION OF USE:

MEDICATION NAME	DOSE	HOW OFTEN	FOR HOW LONG	REASON
1.				
2.				
3.				
4.				
5.				

PLEASE LIST ALL CURRENT SUPPLEMENTS THAT YOU ARE TAKING, THE DAILY DOSE AND DURATION OF USE:

SUPPLEMENT NAME	DOSE	HOW OFTEN	FOR HOW LONG	REASON
1.				
2.				
3.				

HAVE YOU BEEN HOSPITALIZED IN THE PAST? N Y – IF YES, PLEASE DESCRIBE:

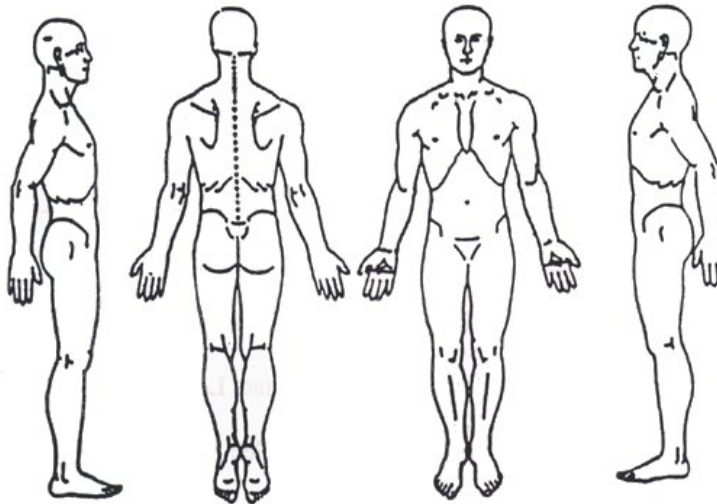
TYPE OF ILLNESS OR SUGERY	HOSPITAL	CITY	YEAR

PLEASE LIST ANY PAST INJURIES:

TYPE OF INJURY	HOW DID IT HAPPEN?	YEAR

DO YOU HAVE ANY MUSCLE OR JOINT PAIN? Y N

IF YES, PLEASE INDICATE WHERE ON THE FOLLOWING DIAGRAM:



INFORMED CONSENT TO TREATMENT

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr. Tara Andresen, ND will take a thorough case history, perform a physical examination, including a breast exam and urinalysis if indicated.

It is very important that you inform your Naturopathic Doctor immediately of any disease that you are suffering from and any prescription medications/over-the-counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case, the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by Naturopathic Medicine. These include, but are not limited to:

- Allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Rare pain, bruising or injury from acupuncture or B12 injections.
- Fainting or puncturing of an organ with acupuncture needles.
- Aggravation of pre-existing symptoms.

I understand:

- That a record will be kept of health services provided to me. This record is kept confidential and will not be released to others unless so directed by myself or unless the law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers.
- That treatment results are not guaranteed. I do not expect my Naturopathic Doctor to be able to anticipate all risks and complications. I understand that my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions that I may have. With this knowledge, I voluntarily consent to Naturopathic care. I intend for this consent form to cover the entire course of treatment and understand that I am free to withdraw my consent at any time.

Patient Name (please print)

Signature Patient or Guardian

Date

Naturopathic Doctor

ND Signature

SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms.

<http://www.sourcecentre.ca/about/more/terms-service/>

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at <http://www.sourcecentre.ca/about/more/privacy/>

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y N

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature _____

Client Name _____ Date _____

Signature of parent or Guardian (for anyone under the age of 18):

Signature _____

Guardian/Parent Name _____ Date _____