TRI·HEALTH
WELLNESS CENTRE

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***please note that this form must be signed prior to your 1st appointment**

**Informed Consent**
**to Naturopathic Diagnostic & Treatment Procedures**

Patient Name _____
Address _____
Phone # _____

In order to clarify my position as a health care practitioner and my mutual responsibility in health care, I, _____, ND ask for your co-operation in reading and signing this statement of informed consent:

Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, Non-invasive methods are used for assessment of bodily function and natural therapeutics are used in order to correct imbalances. The credentials of your naturopathic doctor is one with a minimum of 8 years university equivalent including 4 years undergraduate and 4 years post graduate (with clinical component) at an accredited naturopathic medical college in toronto, Naturopathic doctors (N.D.'s) are not medical doctors (M.D.'s). Therefore if standard medical treatment (drugs, surgery, *etc.*) is necessary, it must be obtained from a medical doctor.
Your signature is required before any treatment is rendered. Your signature acknowledges the following:

1. You have read the foregoing information and that you understand that you are ultimately responsible for your own health.

2. As a naturopathic doctor I will take a thorough personal and family history, perform a physical exam and request and review laboratory testing. After collecting the necessary information; diagnosis, treatment and/or referral to other health care professionals are made based upon the assessment of conditions revealed.

3. As a naturopathic doctor, I facilitate your healing process in a manner that is compatible with your beliefs and level of commitment.

4. it is very important that you inform me, of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise me immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

5. While changes in dietary habits are not a prerequisite for treatment, failure to follow the recommended nutritional and exercise programs could undermine the expected results.

6. you understand that that it takes time to feel better when using naturopathic medicine. Some patients of naturopathic medicine notice a difference after 4 visits while others see changes sooner. You accept that positive changes will occur more rapidly with increased compliance.

7. You are accepting or rejecting this naturopathic medical care of your own free will and choice. You are free to withdraw your consent and to discontinue treatment at any time.

8. You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered (by the end of each visit), unless prior arrangements have been made. You acknowledge that canceling or rescheduling of appointments must be done 24 hours in advance otherwise a 50.00 cancellation fee will apply.

9. If you have any questions regarding your treatment program, you will clarify these issues with your naturopathic doctor.

10. You are not an agent of any private, local, county, provincial or federal agency attempting to gather information without stating your intention to do so.

11. There are some slight health risks associated with treatment by naturopathic medicine.
...These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise me of any allergies you may have
- Pain, bruising or injury from acupuncture
- Muscle strains and sprains, disc injuries from spinal manipulation
- There is a very small potential risk for stroke in neck manipulation. Patients are thoroughly screened prior to neck manipulation.
- My staff and I are trained to handle emergencies should the need arise.

I _____ (please print), have read, understood and acknowledge the above statements.
Credit card #:_____, expirty date: ___/___, 3-digit code on back: _____ (To secure appointment only---and to ensure 72 hours notice given if rescheduling or cancelling appointment)
Patient or Lawful Representative Signature _____
Date Signed
_____email:_____

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# Patient consent form for collection, use and disclosure of personal information

Privacy of your personal information is an important part of the Tri-Health Wellness Centre (THWC) while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained In the appropriate use and protection of your information.

Our privacy policy outlines what the THWC is doing to ensure that:

- Only necessary information is collected about you;
- We *only* share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;

Our privacy protocols comply with privacy legislation and standards of our regulatory body the College of Naturopaths of Ontario.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

The THWC understands the importance of protecting your personal information.

To help you understand how we are doing that, we have outlined how the THWC is using and disclosing your information:

The Clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for good and services
- To process credit card payments
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

## PATIENT CONSENT

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how the THWC will use my personal information, and the steps that the THWC is taking to protect my information.

I agree that the THWC can collect, use and disclose personal information about _____ as set out above in the
(Patient Name)

information about the THWC's privacy policies.

_____ _____ _____
(Signature) (Print Name) (Date)