handsON Clinic
Osteopathy and Physiotherapy

Naturopathy Patient Intake Form

Name_____ Date:_____

Age _____ Date of Birth_____ Sex: F M

Address_____

City _____ Postal Code_____

Home Phone # _____ Work # _____

Occupation: _____ Emergency Contact:_____
Telephone # _____

E-Mail: _____

How did you hear about this clinic?_____

What are your main health concerns? List in order of importance

1. _____ Since _____ Cause _____
2. _____ Since _____ Cause _____
3. _____ Since _____ Cause _____
4. _____ Since _____ Cause _____

What medications are you currently taking? For how long?

_____

_____

What Medications have you taken in the past? For how long?

Are you currently undergoing any treatments for the health concerns listed above? Y / N

_____

Past medical history (surgeries, hospitalizations, accidents, injuries, traumatic events, etc.)

_____

List any allergies that you may have:_____

Family Health History

	Age	Health
Father		
Mother		
Brother(s)		
Sister(s)		

Health History (please **circle** if you **had** or **have** any of the following):

abscesses	chicken pox	fungal infections	kidney disease	prostatitis	syphilis
alcoholism	chronic fatigue	gallstones	leukemia	rheumatic fever	tonsillitis
allergies	circulatory problems	glaucoma	liver disease	tuberculosis	rubella
amnesia	cold sores	goitre	migraines	scarlet fever	typhoid fever
anemia	colitis	gonorrhea	mononucleosis	senility	venereal warts
anorexia	colon disease	gout	mumps	serious injury	warts
arthritis	compulsive eating	hayfever	parasites/worms	sexual abuse	whooping cough
asthma	depression	heart disease	peritonitis	sinusitis	yellow fever
autoimmune dz	diabetes	hepatitis	pelvic inflammation	skin disease	
bleeding disorders	eczema	genital herpes	pleurisy	Strep throat	
cancer	emphysema	hypertension	pneumonia	stroke	
Candida (yeast)	epilepsy	hypoglycemia		sunstroke	

List any vitamins, supplements, homeopathic, or herbal medications you are taking

_____

_____

How much of the following substances are you using?

Tobacco_____ Alcohol_____ Coffee_____ Recreational Drugs_____

What vaccinations have you had?_____
Any adverse effects from the vaccinations?_____

What exercise do you do and how much?_____

Gynecological History

Age of first menstrual period: _____ Date of last period:_____
Date of last pelvic exam: _____ Date of last pap smear:_____
Did you ever have an abnormal pap smear? Y / N When ?_____ Results:_____
Treatment:_____
Are you sexually active? _____ Do you practice safe sex? _____
Current birth control method:____
Are you trying to get pregnant? Y / N For how long? _____
How long is your menstrual cycle? _____ How long is your menstrual flow? _____
Amount of bleeding :_____ Any bleeding between periods ? _____
Any unusual pelvic pressure or fullness? Y / N When? _____
Any past history of sexually transmitted disease? Y / N

Pregnancies (including miscarriages and abortions)

Date	Gestational Age (of baby)	Complications during pregnancy, labour, and delivery

Stresses (family, work, self, etc)

_____

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NATUROPATHIC FEE SCHEDULE

I understand that the fees are as follows:

VISIT	FEE
INITIAL CONSULTATION (60 – 90 MIN)	$200.00
SUBSEQUENT VISIT (45 MIN)	$ 95.00
BIOMERIDIAN HEALTH ASSESSMENT	$ 90.00
ACUPUNCTURE	$ 95.00

HEALTHY AND ACTIVE PROGRAM $ 525.00 plus HST for Existing patients and $625 Plus HST for New Patients

* Phone consultation more than 5 min up to 15 min- $25.00
* Arranged telephone consultations with the doctor- $ 8.50 for every 5 minutes (Based on an hourly rate)

There are separate fees for treatments involving the administration of specialized substances (e.g. B12/folic acid intra-muscular injection or intravenous injection) based on the amount of substances used. The fee will be discussed before treatment is administered.
Extended health care benefits may also cover naturopathic visits.
Please check your plan details or call your human resources.

Please note that there is a 24-hour cancellation policy. If 24-hour notice is not given, a $50.00 missed appointment fee will be charged.

I agree to pay my account in full at the time of each visit or treatment.

I acknowledge that I may purchase products prescribed by Bernadette Janczak, N.D. from Bernadette Janczak, N.D. or any health food store.

Please sign that you have read the above and acknowledge the fee schedule.

Signature _____ Date _____

INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Patients Name _____
Address _____
City/Town_____ Province_____ Postal Code _____
Phone Number_____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic procedure(s) and have discussed to my satisfaction this and any requests for related information with Bernadette Janczak N.D. I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent / withhold my informed consent for the recommended diagnostic and therapeutic procedure(s) discussed with Dr. Janczak. I also understand that I may change the status of my voluntary informed consent at any time.

_____ _____
Patient or Lawful Representative Signature Date Signed

_____ _____
Witness Signature (advised but not necessary) Witness Relation to patient
Address_____ Town/City_____
Province_____ Postal Code_____
Phone Number_____

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Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We Understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be open and transparent as possible about the way we handle your personal information. I t is important to us to provide this service to our patients.
In this office, the Privacy Information Officer is;

Bernadette Janczak N.D.

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

In this contest form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share you information with you consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.
Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses patient's Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.
This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and insure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other health-care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment

To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to provisions of the Regulated Health Professions Act
Please initial this page----------

- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes.
- To permit potential purchasers, practice brokers or advisors to evaluate the practice
- To allow potential purchasers, practice brokers or advisors to conduct an in preparation for a practice sale
- To deliver you charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of you personal information for the purposes that are listed. If a new purpose arise for the use and/or disclosure of your personal information, we will seek your approval in advance.

You information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the remifications of that decision, and the process.

Patient Consent

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

I know that your office has Privacy Code, and I can ask to see the code at any time.

I agree that HandsOn Clinic can collect, use and disclose personal information about

_____as set out above in the information about the office's privacy policies
(Patient's Name)

Signature_____ Print Name _____

Date_____ Witness _____