handsON Clinic

Osteopathy and Physiotherapy

325 Central Prkw West, Unit 38
Mississauga, ON L5B 3X9, TEL: 905-272-6969
www.handsonosteopath.com

DATE:

Child's Name: _________________________ DOB: __________________ Age: ________

Child's Sex: M / F Weight: ___________ Height: ___________

Address: ____City: ____________________
Postal Code: __________ Referred by: ____

Parent/Guardian's Names: ____
Address (if different from above) ____
Home Phone: _________________________ Work Phone: _____________________________

Family doctor and/or pediatrician: ____

Do you have extended health care benefits? Y / N

Authorization to Release Information

I hereby authorize the release of any medical information to:__________________________________

Date: _______________ Signed:____
(parent/ guardian of minor must be over 16 yrs old)

What are the child's main health concerns? Please list in order of importance.

1. ______________________________ Since __________ Cause ______________________________
2. ______________________________ Since __________ Cause ______________________________
3. ______________________________ Since __________ Cause ______________________________

What medication is the child currently taking?

1. _______________________________________
2. _______________________________________
3. _______________________________________

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

Immunizations (please **circle** the ones your child has had).

measles mumps rubella smallpox polio oral polio
diphtheria pertussis tetanus hepatitis influenza

Has your child had any adverse effects from any of them? Y / N

Childhood Illnesses (please **circle** the ones your child has had):

measles	mumps	pneumonia	chicken pox
scarlet fever	rubella	rheumatic fever	frequent colds
tonsillitis	ear infection	diphtheria	pertussis

Other: ____
Allergies: ____

Symptoms (please **circle** and use a **"P"** for past symptoms)

eczema	nosebleeds	easy bruising	diarrhea
constipation	body/breath odour	change in appetite	vomiting
stomach aches	blood in stools	burning/painful urination	frequent urination
bedwetting	blood in urine	sore throats	wheezing
cough	hearing loss	ringing in ears	ear infection
grinding teeth	cries easily	sleep problems	night sweats
hair loss	dizzy spells	tendency to bleed	seizures

skin conditions (warts, eczema, abscesses, cold sores, rash, etc.)

Birth History

Term (please circle) Full Premature Late

Weight at birth: ____________ Length of labour: ________hrs Complications: ______________________

C-section: ___________ Vaginal birth: __________ Forceps delivery: ___________

Did your infant experience any of the following at birth or soon after (please circle)?

jaundice birth defect colic seizures birth injury rashes

Other: ____

General Information

Child's sleep patterns: ____

Age began: sitting __________ crawling___________ walking_________ talking_______

Food intolerance/allergies:____

Feeding (please circle): breast_____ How long? __________
formula _________
milk (soy, cow, goat, nut/seed, other)

Age at which solid foods were introduced: _________

Which foods were introduced first? ____

Diet in a typical day :

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks/Beverages: ____

Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of you 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 heath 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 Swiftcurrent 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 ____

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_____________________________

CHANGE TO INFORMED CONSENT

I do hereby voluntarily consent/ withhold/withdraw my informed consent for the recommended diagnostic and therapeutic procedure(s) as 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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NATUROPATHIC FEE SCHEDULE

I understand that the fees are as follows:

VISIT	***FEE***
INITIAL CONSULTATION (60 – 90 MIN)	$200.00
SUBSEQUENT VISIT (45 MIN)	$ 85.00 TO $ 95.00
BIOMERIDIAN HEALTH ASSESSMENT	$ 90.00
ACUPUNCTURE	$ 75.00

HEALTHY AND ACTIVE PROGRAM $ 505.00 plus HST for Existing patients and $605 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 $45.00 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 ________________