



Kleinburg Integrative Health Naturopathic Informed Consent

I would like to take this opportunity to welcome you to our Clinic! KIHCLINIC utilizes the principles of **Naturopathic Medicine** and other supportive therapies to assist the body's own ability to heal and to improve the quality of life.

Naturopathic medicine is the treatment and prevention of diseases 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. A thorough case history will be taken, a physical examination performed as well as the collection of case specific blood tests and/or blood test records.

Your **Naturopathic Doctor** (ND) will conduct a thorough case history, conduct a physical exam if necessary, and may utilize specific blood and/or urinary laboratory reports as part of the treatment work-up. It is important that you disclose any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please also disclose 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.

I understand and am aware of the following:

- ☐ The clinic does not guarantee treatment results.
- ☐ That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- ☐ I am free to withdraw my consent and to discontinue treatment at any time.
- ☐ **Any treatment** or advice provided to me as a patient of the clinic is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider.
- ☐ I am at **liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in Ontario.**
- ☐ I am aware that **no part of my treatment is covered by OHIP** and that I am solely responsible for **payment at the time services are rendered.**
- ☐ My ND reserves the right to determine which cases fall outside of his/her scope of practice, in which case an **appropriate referral will be recommended.**
- ☐ **That if I need to reschedule an appointment I must give 24hrs notice for weekday appointments and for Saturday appointments I must contact the clinic 48 hours in advance. If I do not show up for my appointment at all and do not give any notice that I will be contacted and invoiced 100% of the visit fee. If I contact the clinic with insufficient notice (i.e. less than 24-48hrs, depending on the day) then I will be notified and then invoiced 50% of the regular visit**

As with any treatment, there are rare health risks associated with various naturopathic treatments. They are based on the specific treatment you receive and 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 make known any allergies you may have.
- ☐ Pain, bruising or injury from acupuncture or intravenous therapy
- ☐ Though extremely rare, fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa are possible.



- ☐ The staff is trained to handle emergencies should the need arise.

As a new patient of Kleinburg Integrative Health clinic, I have read the information and understand that this approach to health care is based on **naturopathic principles including holistic care**. As this is an in depth approach to health, I recognize that even the gentlest therapies can potentially have complications in certain conditions, types of populations or those on multiple medications. The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

Patient Name: (Please print name): _____

Signature of Patient or Guardian: _____ Date: _____

Naturopathic Doctor: _____

PATIENT CONSENT FOR COLLECTION AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of your Naturopathic healthcare. 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.

It is understood that your personal information is of a sensitive nature. Any staff member who comes in contact with this information will have your signed consent and will be trained in the appropriate use and protection of your information.

Our privacy policy outlines what this clinic 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, CONO (College of Naturopaths of Ontario)
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How the Clinic collects, uses and discloses patients' personal 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 remind you of upcoming appointments



- To follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirement to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

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.

PATIENT CONSENT

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

I consent to the collection, use and disclosure of my personal information as set out in the above privacy policies.

Signature _____

Print name _____

Date _____