CONSENT TO TREATMENT & FEES POLICY

Naturopathic medicine is the treatment and prevention of diseases using natural means. Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of an individual. Gentle techniques are used to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counseling, clinical nutrition (primarily via supplementation), botanical medicine, homeopathy, asian medicine (herbs and/or acupuncture) and physical medicine.

It is important to note that even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such as heart, liver or kidney disease.

It is very important, therefore, that you inform your naturopathic doctor, immediately of any disease process that you are suffering from as well as any medications (prescription or over the counter) that you are taking. If you are pregnant, suspect you are pregnant or you are breast-feeding, advice your doctor immediately.

Health risks associated with naturopathic medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

Payment (in CDN$) is to be made at the time of the visit as follows*:

Initial Visit (75min):	$160
Second Visit (45min):	$110
Subsequent Visit:	$ 86

Initial Visit (1 hour)- children**, student*** or senior:	$130
Second Visit (45min)- children**, student*** or senior:	$ 90
Subsequent Visit- children**, student*** or senior:	$ 65

$75 for completing insurance forms, copying patient files, telephone consultations longer than 10 minutes, and missed appointments without 24-hour notification.

* HST included

** Children: less than 16 years of age

*** Student: in school full-time with valid photo id

Health supplements and products are individually priced. Patients are not required to purchase them from this office and are free to choose where to purchase them. Most insurance companies do not cover the supplements that we prescribe and dispense.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company- we will provide you with all of the information necessary to send your claim for reimbursement.

Prices are subject to change without prior notice.

Consent Regarding Personal Information:

Privacy of your personal information is an important part of our clinic while providing you with quality naturopathic care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information personably. We will try to be as open and transparent as possible about the way we handle your personal information.

_____ Initials — I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. Storage, retention, and destruction of your personal information complies with the existing legislation, and privacy protection protocols outlined by the regulatory body, the Board of Directors of Drugless Therapy-Naturopathy. I understand hat I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials — I understand the Naturopathic Doctor will answer any questions that I have to to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____ Initials — I understand that fees and supplements are to be paid for at the time of the consultation.

_____ Initials — I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Parent/Guardian: _____

Date: _____