

PLEASE READ FIRST

Dear New Patient,

Thank you for the confidence and commitment you are demonstrating through your decision to pursue Naturopathic health care. You only have one life and one body, so congratulations for taking a step towards health. The benefits of optimal health will be proportional to the efforts and dedication that you put into your daily choices. You have the option to feel better, live healthier, look and act younger and live longer. It is found that lasting improvements in one's health take place in the presence of heightened focus, dedication and education.

As Naturopaths, we commit to helping you achieve your health goals through consultation, laboratory testing and educational material.

Your careful consideration of each of the enclosed forms will enhance my efficiency and accuracy, and ensure that we get the most out of our consultation time. There is a lot of material to cover, so please leave yourself enough time. If you would like your package reviewed before your appointment, please drop it off at the office ahead of time, otherwise bring all the completed forms with you to your initial visit.

Please read and complete the materials in the order that you have received them in the package. If you need further clarification on any of the material in the package, please feel free to call the office at 519-772-0292 or email us at info@vibrant-living.ca or at our individual contacts below.

Thank you for your time, and we look forward to working with you to achieve your health goals.

Robin Walsh BSc, ND	robin@vibrant-living.ca
Kristijana Rakic BSc, ND	kristijana@vibrant-living.ca
Laura Stix BSc, ND	laura@vibrant-living.ca
Vanessa Cowlen, Manager	vanessa@vibrant-living.ca

NOTE – Please start the diet diary as soon as you get this package, as it takes time. It is also more valuable if the diary reflects your usual dietary habits.

Office Policies

To facilitate the efficiency of the office, and to ensure that you will derive the maximum benefit for the care provided, the following office policies have been established:

1. In order to keep accounts to a minimum full payment is required at the time of your visit. We accept cash, cheque, debit, Visa and Mastercard. Thank you for your cooperation.
2. If at all possible, we have a 24 hour cancellation policy in effect in the event that you cannot make your appointment so that someone on the waiting list could be accommodated. We understand that there are extenuating circumstances, which will be taken into consideration; however chronic missed appointments will be billed for 50% of the appointment fee. Our answering machine is available during off hours to take any messages.
3. With the number of patients that are thoroughly interviewed, timing is crucial. For the respect and convenience of our clients and for the efficiency of the clinic we are required to keep scheduled appointments on time. However, complications and emergencies do arise on both ends, which again will be taken into consideration. Please note that when you arrive late for your appointment, only the balance of time that was booked for you can be used.
4. We reserve the right to discharge any case where,
 - ◆ The Naturopath feels that the case is beyond the scope of practice of this clinic
 - ◆ The patient refuses to cooperate with the recommendations mutually agreed upon
5. Telephone consultations provide a professional service and such may be subjected to a fee on the discretion of the Naturopathic Doctor.

Robin Walsh BAsC, ND
Kristijana Rakic BSc, ND
Laura Stix BSc, ND

NATUROPATHIC PEDIATRIC INTAKE FORM

Patients Name: _____

Age: _____ Date of Birth: _____ Sex: M F

Mother's Name: _____ Father's Name: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

How did you hear about this clinic? _____

1) Primary reason for coming to the clinic? _____

2) When did it first occur? _____

3) What makes it better? _____

4) What makes it worse? _____

5) Have you consulted any other health care practitioners regarding this condition? YN

Please explain therapy and results: _____

6) Please list any other health concerns you have at this time: _____

FAMILY HEALTH HISTORY

7) Please indicate whether there is any history of the following conditions in your family and give details below:

Heart Disease	Hypertension	Cancer	Diabetes
Arthritis Allergies	Birth Defects	Tuberculosis	Mental Illness
Multiple Sclerosis	Auto-immune Disorders	Asthma	Psoriasis

Eczema or any other conditions: _____

8) Please indicate if any siblings have a similar condition or any listed above: _____

CHILD'S HEALTH HISTORY

9) Mother's age at child's birth: _____ Father's age: _____

10) Number of previous pregnancies by natural mother, miscarriages or complications: _____

11) Please indicate whether any of the following conditions were present during the pregnancy:

Bleeding	Nausea	Illness	Hypertension	Medication
Diabetes	Physical or Emotional Trauma		Smoking	Alcohol Drug Consumption

12) Was the birth process Vaginal C-Section

Was any medical intervention used: Y N (eg forceps, c-section, epidural anesthesia etc.)

If yes, please explain: _____

13) Term: Full Premature Late Weight: _____

14) Was the child breast fed within the first 10 hours after birth? Y N

15) Was the child breast fed at all? Y N How long? _____

16) If formula was given to the child, which kind (milk, soya) _____

17) Age at which solid food were introduced _____

18) Did your child require any medical attention, hospitalization or medication as an infant (before age 2) Y N

Please list all surgeries, their approximate dates, why they were performed and if you feel they were successful _____

20) Please circle the conditions that your child has been vaccinated for:

Measles Mumps Polio DPT MMR Tetnus Diphtheria Influenza Influenza
 Chicken Pox Meningitis

Other _____

21) Has your child had the following problems? Jaundice Colic Fever

Blue Baby Diarrhea Constipation Seizures Birth Defects Rashes

Cerebral Palsy Birth injuries Pneumonia Frequent colds

Tonsillitis Ear infection Unusual weight gain/loss

Other _____

22) List any medication your child has been on (asprin, Tylenol, decongestants, antibiotics, anti-histamines)_____

23) List any known allergies your child may have (environmental, food, medications etc.):

24) Please mention any other information which has not already been mentioned that you feel may be pertinent to the treatment of your child:

Declaration and Consent to Treatment

- I) This is to acknowledge that I have been informed and understand that:
- i) any treatment advise provided to me as a client of a Naturopathic Doctor working for Vibrant Living is not mutually exclusive from any treatment or advise that I may now be receiving or may in the future receive from another licensed health care provider
 - ii) I am at liberty to seek or continue medical care from physicians or other health care providers who are qualified to practice in Ontario
 - iii) The Naturopathic Doctor working at Vibrant Living has not suggested to me to refrain from seeking or following the advice of another licensed health care practitioner

II) I declare that I have received a full and complete explanation of the treatment and or services that I will receive from the Naturopathic Doctor working at Vibrant Living, and hereby authorize and consent to treatment

III) I agree to pay the full account at the time of each visit or treatment

IV) I recognize that results are not guaranteed, and that even the gentlest of therapies potentially have complications in certain physiological conditions, in very young children or those on multiple medications. The slight health risks of Naturopathic treatments include, but are not limited to; aggravation of a preexisting symptom, allergic reactions to supplements or herbs, pain, fainting, bruising or injury from acupuncture needles.

Dated _____

Client Name _____

Client Signature _____

Signature of Treating Naturopathic Doctor

- Robin Walsh BSc, ND
- Kristijana Rakic BSc, ND
- Laura Stix BSc, ND

Patient Consent Form For Collection, Use And Disclosure Of 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. We are committed to collecting, using and disclosing your personal information responsibly. We will be as open as possible about the way we handle your personal information.

In this clinic, Robin Walsh, N.D. is the Privacy Information Officer.

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 is available for your review upon request. It outlines what our 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, the Board of Directors of Drugless Therapy – Naturopathy.

How Our Clinic Collects, Uses And Discloses Patients' Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic 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 billings
- ◆ To complete claims for insurance purposes
- ◆ To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy, acting under the authority of the Drugless Practitioners’ Act.
- ◆ To invoice for goods and services
- ◆ To process credit card payments
- ◆ To collect unpaid accounts
- ◆ To assist this clinic to comply with all regulatory requirements
- ◆ To comply generally with the law
- ◆ To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

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 your personal information as outlined above.

Patient Consent

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

I agree that Vibrant Living can collect, use and disclose personal information about:

(print full name of patient)

as set out above in the information about the clinic’s privacy policies.

Signature of Patient

Date

Fee Schedule - As of September 1st, 2013

Naturopathic Care

**These services are not currently covered by OHIP, but are covered by extended health care plans

**HST not included

Initial Consult	\$160.00
Initial Consult for Children 10 and under	\$150.00
Naturopathic Follow Up	\$75.00
Naturopathic Review	\$40.00
Acupuncture	\$40.00-\$70.00
Forms	\$10.00

Lab Services

Zinc Tally	\$3.00
Koenisburg Test	\$8.00
Urinary Indican	\$20.00
Urinary Chemstrip	\$4.00
Oxidata	\$15.00
Hair Analysis, Salivary Hormone Testing, Food Allergy Testing – prices vary based on tests	

I have read and fully understand the above description of this fee system and agree to honour it.

Client/Guardian's Signature

Date