SOMERSET HEALTH & WELLNESS CENTRE

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Welcome to the Somerset Health and Wellness Centre!

Please complete the intake forms enclosed in this package prior to our first visit together. It is important that you fill out the forms completely and accurately so that our first meeting can be as productive as possible. All information is strictly confidential.

Your first visit will last anywhere from 1.5 to 2 hours and will be spent going over your health concerns and will include a relevant physical exam if time permits. During this initial consultation, your naturopathic doctor will collect the information required to make an assessment of your situation. She may recommend certain diagnostic tests in order to gain a better understanding of your health status. A urinalysis is included in all initial visits. In most cases, a second follow-up visit will be scheduled and may take 1 to 1.5 hours to complete. This visit will be used to complete the physical exam, to discuss the results of your test(s) and to implement a treatment plan. Your treatment plan may include any combination of dietary recommendations, lifestyle changes, herbs, Chinese medicine, acupuncture, homeopathic remedies, or nutritional supplements. Subsequent visits will be booked, as necessary, to review your progress and make appropriate changes to your program. Follow-up visits are usually scheduled for 30-45 minutes.

Payment for appointments is required at the end of each visit by cash, cheque, debit, Visa or Mastercard. There is a $20.00 charge for all returned cheques. While OHIP does not cover naturopathic services, many private insurance policies offer partial or complete coverage. Please check your policy to see whether you are covered for naturopathic medicine. Official receipts will be issued at the end of each visit so that you may be reimbursed directly by your insurance company.

Any supplements or remedies prescribed can usually be purchased at the clinic dispensary. Every effort has been made to ensure that all products are of the highest quality and of reasonable cost. You are, of course, welcome to purchase your supplements elsewhere.

If you are unable to make a scheduled appointment, please let us know as soon as possible so that we can provide care to another patient. Please provide at least 24 hours notice or full visit fees will apply.

Directions and parking: Our clinic is easily accessible off of highway 417. Exit at Metcalfe and follow the road as it curves around the Museum of Nature. Turn left on Elgin. We suggest you park on Maclaren Street, where there is 2 hour metered parking. The entrance to our clinic is on Somerset St., just at the corner of Elgin above the White Cross Pharmacy.

We are looking forward to serving you in health!

Sincerely,

Drs. Luck, Lock, Simone and Van Zeyl

Naturopathic Confidential Adult Intake *please print*

Welcome to the naturopathic clinic at The Somerset Health & Wellness Centre. Our philosophy of health care is to seek to understand all the factors that may be affecting your health. Please complete this form as thoroughly as possible, as your responses will assist your Naturopathic Doctor in making appropriate recommendations to support your return to optimal health. Please bring all of the completed forms in this package with you to your first visit

Please also bring the following to your first visit:

- Any recent bloodwork (within past year), if you do not have a copy we can request a copy from your doctor
- Any supplements, medication, or remedies that you are currently taking

Today's Date: _____

Name: _____ Age: _____ Gender: _____

Date of Birth: _____/_____/_____ Blood Type _____ (+ or -)
DD/ MM/ YY

Address:

_____
Street & Apt. City Province Postal Code

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

Occupation: _____ Hours per week: _____ Retired _____

Employer: _____

Live with: □Spouse □Partner □Parents □Children □ Friends □Alone □Other _____

Emergency Contact: _____Phone: _____
Name and Relationship

How did you hear about us?_____

HEALTHCARE PROVIDERS:

Primary Health Care Physician: _____ Phone: _____

When was your last physical exam? _____

Are you currently under the care of a specialist? □Yes □No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Are you currently under the care of alternative health care providers? □Yes □No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Current Health Concerns:

Why did you choose to come to this clinic?

What 3 expectations do you have from THIS VISIT to our clinic?
1)
2)
3)

What LONG TERM expectations do you have from working with our clinic?

What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? (Please rate from 1 to 10, 10 being 100 % committed).

1 2 3 4 5 6 7 8 9 1 0

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list):

What behaviors or lifestyle habits do you currently engage in regularly that you believe are not supportive for your optimal health? (Please list):

Who do you know that will sincerely support you with the potential lifestyle changes you will be making?

HEALTH CONCERNS

Please list your health concerns, in order of greatest importance to you.
State the main reason for your visit today. Describe in detail any specific health condition. Include when it started and where, any associated symptoms, and any treatments used for the condition. Is there anything that makes this problem better or worse?
1. _____
2. _____
3. _____
4. _____
5. _____

Are there any events (surgeries, drug reactions, life trauma etc.) that you can identify as having caused or clearly aggravated your health problems?
_____
_____

When was the last time you felt well?

_____
_____

Allergies: Are you allergic to medicines, herbs, foods, animals, or any other substance?

Substance	Reaction

Current Medications: (Prescription and over-the-counter)

Name of Drug	Reason for Drug	Dose (mg/etc)	For how long

Are there any medications that you have used for more than 5 years of your life, which you have not already mentioned?

_____

_____

Number of times on antibiotics in the past 10 years: _____

Please check (√) any of the following that you take:

- □ Antacids (Rolaids/Tums)
- □ Antibiotics (oral or topical)
- □ Antihistamines (Claritin/Benadryl)
- □ Cortisone (cream or pills)
- □ Cough or cold medication
- □ Diet pills
- □ Laxatives
- □ Flu Vaccinations
- □ Pain Relievers (Aspirin, Tylenol, Motrin)
- □ Sleeping Pills
- □ Thyroid Medication
- □ Oral contraceptives /HRT

Vitamins, Minerals and Supplements: What you are taking and what dosages?

Name of Supplement	Reason	Dose	For how long

Family History:

Please indicate in the chart below if any close relative (child, sibling, parent, maternal or paternal grandparent, has had any health condition(s) including the following:

- □ High blood pressure
- □ Heart attack
- □ Diabetes
- □ Skin disorders
- □ Depression
- □ Asthma
- □ Allergies
- □ Alcohol/Drug Abuse
- □ Cancer
- □ Osteoporosis
- □ Mental Illness
- □ Other serious illness

Family member	Current Age	Age at Death	Health Problems or Cause of Death
Mother			
Maternal grandmother			
Maternal grandfather			
Father			
Paternal grandmother			
Paternal grandfather			
Siblings			
Children			

□ **I don't know my family medical history**

Past Medical History: Childhood Illnesses: Check (√) if you had it:

- □ Chickenpox
- □ Coxsackie
- □ Diphtheria
- □ Fifth's
- □ Tuberculosis
- □ German Measles (Rubella)
- □ Mono
- □ Mumps
- □ Polio
- □ Rheumatic Fever
- □ Rotavirus
- □ Smallpox
- □ Typhoid
- □ Measles (Rubeola)
- □ Whooping Cough

Medical Conditions: Check (√) if you have had any of the following:
Indicate if it is a Y (Yes -current) or Past Condition (P)

Condition	Y	P	Condition	Y	P	Condition	Y	P	Condition	Y	P
□Abortion			□Eating Disorder			□Hypoglycemia			□Psoriasis		
□Acne, Boils, Impetigo			□Eczema			□Infertility			□Raynaud's Disease		
□Addison's Disease			□Endometriosis			□Irritable Bowel			□Rheumatoid Arthritis		
□Alcoholism			□Environmental Illness			□Jaundice			□Rickets		
□Allergies			□Epilepsy			□Joint Problems			□Schizophrenia		
□Allergies (Environmental)			□Erectile Dysfunction			□Keloids			□Seizures		
□Anemia			□Eye Problems			□Kidney Problems			□Sexually Transmitted Infection		
□Appendicitis			□Fainting			□Liver Disease			□Shingles		
□Asthma			□Fibrocystic Breast Disease			□Low Blood Pressure			□Sinusitis		
□Autoimmune			□Fibromylagia			□Lung Disease			□Spleen Disease		
□Backpain/Sciatica			□Food Poisoning			□Lupus			□Stomach/Duodenum Ulcers		
□Bipolar Disease			□Fracture			□Malnutrition			□Strep Throat		
□Bladder Problems			□Gall Bladder Disease			□Meningitis			□Stroke		
□Bleeding problems			□Genital Herpes			□Migraine Headaches			□Substance Abuse		
□Bronchitis			□Genital Warts			□Miscarriage			□Suicidal Tendencies		
□Candida (yeast)			□Gestational Diabetes			□Mononucleosis			□Syphilis		
□Canker Sores			□Glaucoma			□Multiple Sclerosis			□Thyroid: overactive		
□Chlamydia			□Gonorrhea			□Myasthenia Gravis			□Thyroid: underactive		
□Chronic Fatigue			□Gout			□Numbness			□Tonsillitis		
□Chronic Infections			□Hay Fever			□Obesity			□Tuberculosis		
□Circulation Problems			□Heart attack, angina			□Osteoarthritis			□Ulcers		
□Clinical Depression			□Heart Disease			□Osteoporosis			□Urticaria		
□Colitis (inflamed bowel)			□Heart Problems			□Ovarian Cysts			□Uterine Fibroids		
□Constipation			□Hepatitis			□Painful Periods			□Uterine Prolapse		
□Cramps			□Herpes			□Palpitation			□Vaginitis (recurrent)		
□Cushing's Disease			□Herpes (cold sores)			□Pancreatic Disease			□Varicose Veins		
□Depression/Anxiety			□Hiatal Hernia			□Parasites/Worms			□Warts		
□Diabetes			□High Blood Pressure			□PMS			□Weight Changes		
□Diarrhea			□High Cholesterol			□Pneumonia, Pleurisy			□Wilson's Disease		
□Diverticulitis			□HIV/AIDS or ARC			□Pre-eclampsia			□Cancer (please specify type):		
□Dizziness			□Human Papillovirus (HPV)			□Pregnancy Problems			□Other: (specify)		
□Ear Infections			□Hypertension			□Prostate Problems					

Hospitalizations and Surgeries:
_____ Year: _____
_____ Year: _____

X-Rays, CT Scans, or Other Diagnostic Studies:
_____
_____

Accidents/Injuries: (Type, Date and Important Details)
_____
_____

How many times per year do you get a cold/flu? _____
On average, how many days does it take to recover? _____

Vaccine History: (Circle if received)
Hep B Hib Pertussis Tetanus Polio MMR HPV Flu Other: _____
Any adverse reactions? _____

Typical Food Intake:
Breakfast:_____
_____
Lunch: _____
_____
Dinner: _____
_____
Snacks: _____
Beverages: _____
How much water per day?:_____

Do you follow a specific diet regime? □Vegetarian □Vegan □Other _____

Do you consume organic foods? □Never □1-3x/wk □3-5x/wk □5-7x/wk □Daily

Do you have any food cravings? ____ If yes, please list**:** _____

Do you monitor your intake of □Fat □Salt □Sugar □Fibre □Carbohydrate □Protein

Please indicate the number of times per week that you eat or drink the following:

Food	# /wk	Food	# /wk	Food	# /wk
Fruits/Fruit juices		Soy products (tofu, soy milk, etc.)		Fast food (MacDonalds, etc.)	
Vegetables/Vegetable juices		Soft drinks (regular)		Coffee	
Luncheon meat/smoked meat		Soft drinks (diet)		Regular Tea	
White flour/white rice products		Salty snack foods (chips, etc.)		Herbal tea/Green tea	
Margerine		Sweets (candies, cookies, etc.)		Wine	
Milk/Cheese Products		Artificial sweeteners (Splenda, etc.)		Other alcoholic drinks	
Microwaved foods		Meal replacement bars/drinks		Glasses of water per day:	

Is there anything about your diet you would like to change?
_____
_____

Height: _____ Weight:_____ Weight 1 year ago: _____ Desired weight: _____

Have you had an unexplained loss or gain of weight of 10lbs or more in the past 6 months? □Yes □No

Regular Exercise:

Type	Time per Session	Frequency (times per week)	Practiced How Long

Bowel Movement Habits: Please (√)

Frequency (how often): □Once a day □Every other day □Every week □Other? _____

Color: □Dark □Brown □Green □Yellow □White □Grey

Consistency: □Soft □Hard □Watery

Any: □Mucus □Blood →If Blood is present: □Bright □Dark

Urine Habits: Please Check (√)

Frequency (how often per 24 hour period): _____

Color: □Dark □Light Yellow □Colorless

Character: □Cloudy □Clear □Concentrated □Dilute Any Odour? _____

Any: □Sediment □Blood →If Blood is present: □Bright □Dark

□Pain □Incontinence □Difficulty with Stream

Social History & Habits: (Y= Yes & N= No).

Main interests and hobbies? _____

Average # of hours you sleep per night? _____

Sleep well? Y N

Awaken rested? Y N

Have a supportive relationship? Y N

Have a history of abuse? Y N

Any major traumas? Y N

Use recreational drugs? Y N

Been treated for drug dependence? Y N

Drink alcoholic beverages? Y N

Treated for alcoholism? Y N

Do you use tobacco? Y N

→ packs per day? _____

Smoked previously? Y N

→ How many years? _____

Enjoy your work? Y N

Take vacations? Y N

Spend time outside? Y N

Watch television? Y N

→How many hours? _____

Do you drink coffee? Y N

Do you eat three meals a day? Y N

Do you eat out often? Y N

Do you go on diets often? Y N

Do you drink black or green tea? Y N

→How many years? _____

Do you drink cola or other sodas? Y N

→How many years? _____

1. Have you ever felt you should cut down on your drinking or drug use? Y N
2. Have people criticized or complained about your drinking or drug use? Y N
3. Have you ever felt bad or guilty about your drinking or drug use? Y N
4. Have you ever had a drink or drug in the morning to steady your nerves or to get rid of a hangover? Y N
5. Do you use any drugs other than those prescribed by a physician? Y N
6. Has your drinking/drug use caused family, job, or legal problems? Y N

Name of husband/ wife/ partner: _____Occupation: _____

Other members of the household (names and ages):

_____

Do you have any pets? Y N Please list: _____

Relationship Status:

□Single □ Married □Partner □Common-Law □Separated □Divorced □Widowed □Other _____

Are you sexually active now? Y N If No, when were you last sexually active? _____

How long with current partner? _____ (mo/yrs) □Monogamous □Non-Monogamous

Do you use contraceptives? Y N If Yes, what form of contraceptive(s)? _____

Are you pregnant? Y/N re you trying to conceive? _____

Number of: Pregnancies: _____ Abortions: _____ Miscarriages: _____ Live births: _____

Do you perform monthly self-breast exams? □Yes □No

Date of last clinical breast exam (performed by MD or ND):_____

Date of last PAP test (performed by MD or ND): _____

Do you have regular mammograms? □Yes, how often _____ □No

GENERAL HISTORY: (For the following list of symptoms, circle Y for currently experiencing and P for those you've had in the past)

SKIN:			**NOSE & SINUSES:**			**GASTROINTESTINAL:**			**MALE:**		
Rashes	Y	P	Frequent colds	Y	P	Trouble swallowing	Y	P	Hernia	Y	P
Eczema	Y	P	Nasal stuffiness	Y	P	Nausea	Y	P	Enlarged prostate	Y	P
Psoriasis	Y	P	Loss of smell	Y	P	Vomiting	Y	P	Prostatitis/infection	Y	P
Vitiligo	Y	P	Nose bleeds	Y	P	Heartburn	Y	P	Discharge	Y	P
Dryness	Y	P	Nasal Polyps	Y	P	Indigestion	Y	P	Low libido	Y	P
Hives	Y	P	Sinus Infections	Y	P	Bloating	Y	P	Erectile dysfunction	Y	P
Boils	Y	P	Chronic runny nose	Y	P	Abdominal pain	Y	P	Last prostate exam:	Y	P
									____		
Acne	Y	P	Other:	Y	P	Excessive gas	Y	P			
Warts	Y	P	_____			Ulcer	Y	P	**HAEMATOLOGICAL**	Y	P
						Hypoglycemia	Y	P	Anemia	Y	P
HEAD/NECK:			**RESPIRATORY:**			Diabetes	Y	P	Easy bleeding	Y	P
Head injury	Y	P	Cough	Y	P	Jaundice/hepatitis	Y	P	Easy Bruising	Y	P
Headaches	Y	P	Wheezing	Y	P	Colitis or Crohn's	Y	P	Varicose/spider veins	Y	P
Migraines	Y	P	Coughing blood	Y	P	Constipation	Y	P	Hep. A, B, or C	Y	P
Vertigo/Dizziness	Y	P	Difficulty breathing	Y	P	Blood in stool	Y	P	HIV	Y	P
Hair loss	Y	P	Shortness of breath	Y	P	Diarrhea	Y	P			
Dandruff	Y	P	Pain on inhalation	Y	P	Hemorrhoids	Y	P	**MUSCULOSKELETAL**		
Swollen lymph nodes	Y	P	Asthma	Y	P	Eating disorder	Y	P	Muscle pains	Y	P
						Last colonoscopy	Y	P	Joint pains	Y	P
EYES:			Bronchitis	Y	P	_____			Osteoarthritis	Y	P
			Pneumonia	Y	P	Other:	Y	P	Back pain	Y	P
Impaired vision	Y	P	Emphysema	Y	P	_____			Muscle spasms	Y	P
Eye pain	Y	P	Tuberculosis	Y	P				Joint swelling	Y	P
Redness	Y	P	Central chest pain	Y	P	**FEMALE:**			Broken bones	Y	P
Excessive tearing	Y	P				Age of 1st menses			Gout	Y	P
Dryness	Y	P	Other:	Y	P	_____			Other:	Y	P
Double/Blurred vision	Y	P	_____			# of days of menses			_____		
Spots/floaters	Y	P				_____					
Flashing lights	Y	P	**CARDIOVASCULAR:**	Y	P	Length of cycle			**NEUROLOGICAL:**	Y	P
Glaucoma	Y	P				_____			Fainting/Blackouts	Y	P
Cataracts	Y	P	Rapid heart beat	Y	P	Bleeding b/w periods	Y	P	Numbness	Y	P
Discharge/infection	Y	P	High blood pressure	Y	P	Painful periods	Y	P	Tremors	Y	P
Other:	Y	P	Chest pain	Y	P	Irregular Periods	Y	P	Pins & needles	Y	P
_____						Excessive flow	Y	P	Loss of balance	Y	P
			Palpitations	Y	P	PMS	Y	P	Paralysis	Y	P
EARS:	Y	P	Heart murmurs	Y	P	Menopause	Y	P	Speech problems	Y	P
Impaired hearing	Y	P	Rheumatic fever	Y	P	Low libido	Y	P	Memory loss	Y	P
Infection	Y	P	Difficulty breathing	Y	P	Yeast infections	Y	P	Loss of sleep	Y	P
Ringing	Y	P	Leg cramps	Y	P	Vaginal Dryness	Y	P	Nervousness/tension	Y	P
Dizziness	Y	P	Thrombophlebitis	Y	P	Abnormal discharge	Y	P	Irritability	Y	P
Discharge	Y	P	Edema/swollen ankle	Y	P	Pain with intercourse	Y	P	Depression	Y	P
			Cold hands/feet	Y	P	Difficulty conceiving	Y	P			
MOUTH & THROAT:						Pregnancy(s)	Y	P			
Bleeding gums	Y	P	**GENITOURINARY:**			#_____			**GENERALS:**		
Sores in mouth	Y	P	Urgency	Y	P	Miscarriage(s)	Y	P	Weight loss/gain	Y	P
Gum problems	Y	P	Pain on urination	Y	P	#_____			Insomnia	Y	P
Periodontal disease	Y	P	Dribbling/leaking	Y	P	Abortion(s) # _____	Y	P	Fatigue	Y	P
Thrush	Y	P	Frequency at night	Y	P	Endometriosis	Y	P	Night sweats	Y	P
Sore throat	Y	P	Incontinence	Y	P	Uterine fibroids	Y	P	Profuse perspiration	Y	P
Enlarged lymph node	Y	P	Burning pain	Y	P	Ovarian Cysts	Y	P	Weakness	Y	P
Loss of taste	Y	P	Urinary tract infection	Y	P	Cervical Dysplasia	Y	P	Mood Swings	Y	P
Difficulty swallowing	Y	P	Kidney infection	Y	P	Hysterectomy	Y	P	Anxiety	Y	P
			Kidney stones	Y	P	Fibrocystic Breasts	Y	P	Other:	Y	P
			Reduced urine flow	Y	P	Menopause	Y	P	_____		
						Age of onset:					
			STDs (HPV, etc.)	Y	P	_____					
						Last pap smear:					
			Other:	Y	P	_____					
			_____			Other:	Y	P			
						_____					

Toxicity Exposure:

Do you work in the presence of toxic fumes or chemical? Y N
Do any of your hobbies involve toxic materials? Y N
Are you currently exposed to second hand smoke? Y N

Lifestyle and Stress:

What time of day is your energy best: _____ worst: _____

List some important events in your life from the most recent to the most distant.

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Which event has affected you the most and why? _____
_____

How would you describe the emotional climate of your home?

_____
_____
_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____

When you are feeling stress, what helps you to relax or feel better?

_____
_____
_____

Miscellaneous:

How does your condition affect you?

_____
_____

What do you think is the root cause?

_____

What do you feel needs to happen for you to get better?

_____
_____

What do you enjoy most in your life?

_____

Is there any information about your health you would like to add?

_____
_____
_____
_____
_____
_____

Thank you for taking the time to fill out this form.

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Welcome to the naturopathic clinic of the Somerset Health and Wellness Centre. Naturopathic Doctors use the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

You will find that Naturopathic Medicine has some similarities and many differences in comparison to regular medical treatments. Most of our treatments are less invasive and have few side-effects, yet many of our natural treatment methods are very powerful and some side-effects and complications may occur. The extensive training that a licensed and regulated Naturopathic Doctor (ND) receives helps ensure patient safety. The licensed and regulated practitioners of this clinic will inform you of any risks that are involved with certain therapies as they arise, but on rare occasions there may be unforeseen risks.

It is important that the information you include on the intake form is complete. This will help us prevent unwanted drug and/or supplement interactions and prevent us from prescribing products that may exacerbate any existing conditions. It is also important to notify us if you are pregnant, suspect that you may be pregnant, or are breastfeeding.

As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side-effects, and in each case the consequences of not having the diagnosis and/or treatment acted upon.

Some of the risks may include, but are not limited to:

- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplements and herbs; please advise us of any allergies
- Pain, fainting, bruising, or injury from venipuncture or acupuncture
- Muscle strains and sprains, and/or disc injuries from spinal manipulations
- Potential for stroke or emboli is a concern in cervical manipulation; proper pre-requisite tests will be done before such manipulations are performed to prevent such an outcome

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I understand the risks of Naturopathic treatment as stated above and know that I may ask the Naturopathic Doctor to explain any risks to specific treatments as they come up. I also understand that I may refuse any treatment that is offered to me at any time. I will rely on the Naturopathic Doctor to exercise his/her best judgment in my best interests based on his/her present knowledge of my condition and the proposed treatment method.

I confirm that I have read this agreement and consent to any treatments (other than the exemptions listed below) from my Naturopathic Doctor, and I understand that I can withdraw my consent to any treatment at any time. I also understand that I will be responsible for any fees incurred during care and treatment at this clinic.

Exemptions to treatment:_____

Patient's name: _____ Patient's Signature (Guardian if under 18): _____

Naturopathic Doctor: _____ Witness Signature: _____

Date: _____

Informed Consent to Naturopathic Services

The Somerset Health & Wellness Centre has access to functional laboratory services. This enables our naturopathic doctors to perform comprehensive blood work, urine and stool testing, as well as special tests using saliva and hair. In addition, naturopathic doctors can administer Vitamin B12 and folic acid via intramuscular injection. OHIP does not cover laboratory services requested by naturopathic doctors, therefore, patients are required to pay for these services at the time of testing.

The Somerset Health & Wellness Centre also carries a limited selection of professional quality products that are not available through health food stores. OHIP does not cover the cost of these products, thus, patients are required to pay for products that they choose to purchase from their naturopathic doctor. Every effort has been made to ensure that all products are of the highest quality and of reasonable cost. By purchasing remedies from the dispensary, your naturopathic doctor can ensure that you are taking the correct dosage and type of supplement and it can be labelled with your personal dosing information. You are, of course, welcome to purchase your supplements elsewhere. To refill a prescription, please call or email the office with your order and arrange to pick it up during reception office hours. You do not need an appointment to pick up your products. If you prefer to have your products shipped to you please let us know (shipping charges apply). If you are unsure if you should continue taking a remedy your naturopathic doctor has prescribed please contact the office. Please inform your naturopathic doctor if you start any new medications or remedies.

Adult Fees

Office Visits:

Initial Consultation (90 minutes) *In-depth history taking, complaint-oriented physical exam, urinalysis*	$195 – includes urine test
2nd Visit (60 minutes) *General screening physical exam, necessary lab tests, initiation of treatment plan and nutritional consultation*	$140
Follow Up Consultations *Continuation and monitoring of treatment plan* 60 minutes 45 minutes 30 minutes 5-15 minutes	 $140 $ 105 $70 $ 35.00
Acupuncture Treatments (5-10 sessions)	$ 70 each session
***All visit fees are tax exempt as of February 2014**	

Telephone or Skype Consultations*: Follow-up visit fees apply

**. Telephone and Skype consults can be scheduled for patients in lieu of an in-office visit only after an initial visit has been conducted and a treatment plan has been initiated.*

Booking Appointments

Please schedule your appointments in advance. Please plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

Payment for Services

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain this receipt for your insurance or income tax claims, if applicable. Fees may be paid by cash, cheque, direct debit, Visa or MasterCard. We do not accept American Express. A surcharge of $35.00 will apply to any NSF cheques. Please note that refunds are not available for medical services rendered, included lab tests performed, and products that have been sold. Extended insurance plans often offer limited coverage for naturopathic medicine. Plans and policies differ, so please check with your provider regarding your coverage and claim procedures.

Cancelled and Missed Appointments

Please ensure to give at least two business days cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, the full cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of your naturopathic doctor

Confidentiality

Everything that you communicate directly or indirectly to your naturopathic doctor is confidential unless you give written permission to disclose information to a third party. Confidentiality is respected at all times.

It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with a court ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient
5. share information in a supervision format

In Case of Emergency

Emergency services are not available at The Somerset Health & Wellness Centre. In case of an emergency, patients should dial 911, or proceed to the Emergency Department of the nearest hospital.

Statement of Acknowledgment

I, _____ have read, understood and agree to the contents herein
(print name)

Patient Signature: _____

Witness: _____ Date: _____

PATIENT CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Centre 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 try to be as open and transparent as possible about the way we handle your personal information.

Our privacy policy outlines what our Centre 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 or our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy.

How our Centre collects, uses and discloses patients' personal information:

Our Centre understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Centre is using and disclosing your information. This Centre 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 healthcare providers
- To allow us to efficiently follow-up for treatment, care and billing
- 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 Centre 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

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I understand that my patient file will be kept confidential according to the principles outlined above. I also understand that the information in my file will not be shared with anyone outside this Centre unless it is required by law or written consent to share the information with another person (i.e. another healthcare practitioner) has been given by me.

Patient's name:_____ Patient's Signature (Guardian if under 18): _____

Naturopathic Doctor: _____ Witness Signature: _____

Date: _____