3160 Steeles Avenue East, Suite 204 | Markham, ON L3R 4G9
T. 905.477.0200 | **F**. 905.477.0028
E. info@mnhc.ca | **W**. www.mnhc.ca

DECLARATION AND CONSENT TO TREATMENT

Patients Name ____ Date _______________________

Address ____

City ______________________ Province _______________ Postal Code ______________________

This is to acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient of the Clinic is not mutually exclusive from any treatment or advice that I may be receiving or may not be receiving or may in the future receive from another health care provider.
- I am at liberty to seek or continue medical care from a medical doctor or health care providers licensed to practice in Ontario.
- No employee, agent, board member, instructor or anyone else under the Clinic's direction or control has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
- The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.
- I declare that I have received a full and complete explanation of the treatment and/or services that I will receive at the Clinic and hereby authorize and consent to treatment by the Clinic.

I acknowledge the following fee structure:

Visit Fee	$ 90.00 approximately half hour (minimum charge)
Review of Test Results	$170.00
Allergy Test	$190.00
Organ Testing	$170.00
Bio Identical Hormone	$250.00 approximately 1 hour (minimum charge)

Supplements, remedies, laboratory test and other services are charged separately and are not included in the visit fee. There will be no refunds or exchanges on visit fees, supplements, remedies, laboratory test and other services.

A 48-hour notice of cancellation must be given or the full visit fee will be charged. This will be strictly enforced!

I agree to pay my full account at the time of each visit or treatment.

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 try to be as open and transparent as possible about the way we handle your personal information.

In this Clinic, Dr. Lorenzo Diana acts as 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 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 Drugless Therapy & Naturopathy

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

Our Clinic understands the importance of protection 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:

- To access 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 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 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 the MNHC Naturopathic & Medispa Clinic can collect, use and disclose personal information about ______________________________ as set out above in the information about the Clinic's privacy policy.

Dated this__________________ Day of ___________________ 20 ____________

Patient's Signature ____

Naturopathic Doctor's Signature____________________________________

Patient Profile

First Name ____

Last Name ____

Birth Date _______________ Age ___________________ Gender ________________________

Address ____

City _____________________ Province _________________ Postal Code __________________

Home Phone (_____)_____-_____________ Work Phone (_____)_____-_____________

Cell Phone (_____)_____-_____________

Email Address:____

Occupation ____

Employer (Name and Address) ____

Education____

Are you : Married ___ Separated __ Divorced ___ Widowed ___ Common Law ___ Single ___ Other _____

Live with : Spouse ___ Parents ___ Relatives ___ Friends ___ Alone ___ Other____

Next of Kin ____

Relationship ____

Address____

Home Phone (_____)_____-_____________ Work Phone (_____)_____-_____________

Cell Phone (_____)_____-_____________

Email address ____

How did you hear about our clinic ____

What health concerns do you want to talk about today? List in order of importance

1) ___________________________________ 2) ______________________________________

3) ___________________________________ 4) ______________________________________

Past Medical History

What childhood illnesses have you had?

Rubella ___ Mumps ___ Measles ___ Chickenpox ___ Polio ___ Whooping Cough ___

Scarlet Fever ___ Asthma ___ Other _______________

What immunizations have you had?

1) ____ 2) ____

3) ____ 4) ____

Did you have any adverse reactions? ____

When and where did you last receive medical or health care/operations?
____

____

For what reason?____

Health History

Anemia	_____	Arthritis	_____
Asthma	_____	Bleeding Disorder	_____
Cancer	_____	Colitis	_____
Diabetes	_____	Emphysema	_____
Gastric/Duodenal Ulcer	_____	Gout	_____
Heart Murmur	_____	High Blood Pressure	_____
Injury	_____	Kidney Disease	_____
Migraine Headaches	_____	Pneumonia	_____
Thyroid Disorder	_____	Tuberculosis	_____
Venereal Disease	_____		

What medication do you presently take? Include any non-prescription items including vitamins, botanicals (herbs), or homeopathic.
____

____

____

Are you allergic to any medications or other substances?
____

____

Family History

Please list ages, and if deceased what they died from and at what age:

Maternal Side	**Paternal Side**
Grandfather ___________________________	Grandfather_________________________
Grandmother __________________________	Grandmother________________________
Mother _______________________________	Father______________________________

Sisters____

Brothers ____

Has any blood relative had any of the following?

Anemia	_____	Glaucoma	_____
Arthritis	_____	Gout	_____
Arteriosclerosis	_____	Hay Fever	_____
Asthma	_____	Heart Attack	_____
Bleeding Disorder	_____	High Blood Pressure	_____
Cancer	_____	Sickle Cell Anemia	_____
Diabetes	_____	Stroke	_____
Eczema	_____	Thyroid Disorder	_____
Epilepsy/Seizure	_____	Tuberculosis	_____

Social History

Have you traveled outside of Canada in the Past?

When?____

Where?____

Health Habits

How often do you drink? Wine _____________ Beer _____________ Other Alcohol _____________

Do you use tobacco? Yes ______ No ______ If yes, how much per day?_____________________

Total number of years you have smoked____

Do you use drugs? Yes _______ No________

If yes, which drugs and how often ____

How often do you exercise? ____

What forms of exercise do you do? ____

What is your present weight? ____

What was your weight 1 year ago? ____

Our services are covered by most Extended Health Care Plans
Please provide the receptionist with your insurance information booklet
to determine how to best utilize your benefits