Bolton Naturopathic Clinic
64 King Street West, Bolton, ON L7E 1C7
www.boltonnaturopathic.ca
Tel. 905-533-5300

Philip Rouchotas MSc, ND
Naturopathic Doctor
License # 1289

Heidi Fritz MA, ND
Naturopathic Doctor
License # 1565

# CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Gentle, non-invasive techniques are generally used in order to promote healing. As a patient, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the material effects, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight risks associated with treatment by naturopathic therapies. These include but are not limited to:

- Some patients may experience allergic reactions to some supplements and herbs.
- Pain, bruising, or injury from taking blood tests, receiving B12 injections, or from acupuncture

Your ND will explain risks associated with the treatment with you when these exist.

I UNDERSTAND:

- 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.
- My naturopathic doctor does not guarantee treatment results.
- No part of my treatment or testing is covered by OHIP. I am solely responsible for payment at the time of each visit or treatment.
- Costs above those included in the naturopathic visit fee will be explained prior to engaging in any treatment or diagnostic test that involves additional fees.
- I am free to withdraw my consent and to discontinue treatment at any time.

I declare that I have received a full and complete explanation of all of the treatments and services offered by my Naturopathic Doctor and hereby authorize and consent to treatments by Heidi Fritz MA, ND and Philip Rouchotas MSc, ND:

| _____ | _____ | _____ |
|---|---|---|
| Print | Signature | Date |

If the patient is under 18 years of age:

| _____ | _____ | _____ |
|---|---|---|
| Print | Signature of Parent/Gaurdian | Date |

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# CONSENT FOR THE COLLECTION USE AND DISCLOSURE OF PERSONAL INFORMATION (PIPEDA)

As of January 2004, the Canadian government legislated a new Personal Information Protection and Electronic Documents Act (PIPEDA). The privacy of this clinic is made in accordance with the PIPEDA.

We understand the importance of protecting the privacy of your personal information and we are committed to collecting, using, and disclosing your personal information responsibly. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. As such, we strive 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, the standards of our regulatory body, and the law.

We will collect, use, and disclose information about you for the following purposes:

- To assess your health needs and advise you of treatment options.
- To communicate with you and remind you of upcoming appointments.
- To communicate with all other health care providers in your health care team.
- To allow us to efficiently follow-up for treatment, care, and billing.
- To assist in complying with all regulatory requirements and the law, including requirements to advise authorities of child abuse and to report diseases and individuals who may be an imminent threat to themselves or others.
- To invoice for goods and services, process payments, and collect unpaid accounts.

We will not, under any circumstances, supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

PATIENT CONSENT
I have reviewed the above information that explains how my naturopathic doctor will use my personal information. I agree that my naturopathic doctor can collect, use, and disclose my personal information for the purposes listed above.

| _____ | _____ | _____ |
|---|---|---|
| Print | Signature | Date |