Althea Wellness Centre

NEW PATIENT INTAKE FORM - ADULT

Patient Information: **(all fields required)** Marital Status: ◯Single ◯Married/Common Law ◯Widowed ◯Separated/Divorced ◯Other

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ (MMM/DD/YYYY) Age: _____ ◯Male ◯Female Gender: _____

Primary Phone: _____ Other Phone: _____ May we leave messages? ◯YES ◯NO

Address: _____ City: _____ Province: _____ Postal Code: _____

E-mail: _____ Occupation: _____

Do we have your permission to e-mail invoices, statements, treatment plans, and other information related to the services we offer to the provided e-mail address? ◯YES ◯NO

Medical Services Number: _____

Do you have extended health coverage? ◯YES ◯NO Insurer: _____

Policy #: _____ Certificate #: _____ Is the patient the Primary insured? ◯YES ◯NO

Name of Primary insured: _____ Date of Birth: _____ (MMM/DD/YYYY)

Relationship to Primary: ◯Spouse ◯Child ◯Common Law ◯Handicapped Dependent ◯FT Student ◯PT Student

Emergency Contact(s): *Please list at least one emergency contact*

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Do any of your family members attend our clinic? ◯YES ◯NO If yes, name: _____

How did you hear about us? _____

Other Healthcare Providers:

Medical Doctor: _____ Chiropractor: _____

Other: _____ Specify Other : _____

Current Health Concerns:

Please list your primary health concerns, and the reason for visiting us today:

What therapies have you tried in the past, and were they helpful?

Please list any relevant chronic health conditions or diagnoses you would like us to be aware of, including approximate dates:

Personal Health History:

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

Do you have known allergies to drugs, chemicals, or foods? ◯ YES ◯ NO

If yes, please explain:

Please briefly list any surgeries, hospitalizations, accidents, or major medical events, including the year:

Please list all medications and supplements currently being taken (including prescription, over-the-counter, vitamins, herbs, homeopathies):

Are you currently pregnant? ◯ YES ◯ NO If yes, what is your estimated due date? _____ (MMM/DD/YYYY)

Do you have other children? ◯ YES ◯ NO Ages: _____ Are you currently nursing? ◯ YES ◯ NO

Are you currently trying to conceive? ◯ YES ◯ NO Number of pregnancies: _____ Live Births: _____

Miscarriages: _____ Terminations: _____

Personal Diagnosis History: *Select YES (Y) if YOU have been diagnosed with any of the following conditions:*

Acne	☐ YES	AIDS	☐ YES	Alcoholism	☐ YES	Allergies	☐ YES
Anemia	☐ YES	Angina	☐ YES	Anxiety	☐ YES	Arrhythmia	☐ YES
Arthritis	☐ YES	Asthma	☐ YES	Bronchitis	☐ YES	Cancer	☐ YES
Celiac Disease	☐ YES	Colitis	☐ YES	Concussion	☐ YES	Crohn's Disease	☐ YES
Depression	☐ YES	Diabetes	☐ YES	Eating Disorder	☐ YES	Eczema	☐ YES
Edema	☐ YES	Emphysema	☐ YES	Epilepsy	☐ YES	Glaucoma	☐ YES
Heart Disease	☐ YES	Heart Murmur	☐ YES	Hemorrhoids	☐ YES	Hepatitis A/B/C	☐ YES
Hernias	☐ YES	High/Low BP	☐ YES	HSV	☐ YES	Incontinence	☐ YES
Infertility	☐ YES	Jaundice	☐ YES	Kidney Disease	☐ YES	Kidney Stones	☐ YES
Laryngitis	☐ YES	Liver Disease	☐ YES	Multiple Sclerosis	☐ YES	Osteoporosis	☐ YES
Ovarian Cysts	☐ YES	Pancreatitis	☐ YES	Parasites	☐ YES	PMS	☐ YES
Pneumonia	☐ YES	Polyps	☐ YES	Psoriasis	☐ YES	Seizures	☐ YES
Sleep Apnea	☐ YES	STI's	☐ YES	Stroke	☐ YES	Substance Abuse	☐ YES
Thyroid Disease	☐ YES	Tinnitus	☐ YES	Tonsilitis	☐ YES	Ulcers	☐ YES
Uterine Fibroids	☐ YES	UTI's	☐ YES	Varicose veins	☐ YES	Yeast Infections	☐ YES

Other: _____

Immunization History: *Check all that apply:*

Chicken Pox	☐	COVID-19	☐	Diphtheria	☐	Hepatitis A	☐	Hepatitis B	☐
HPV	☐	Influenzas (Flu)	☐	MMRV	☐	Meningococcal C	☐	Pertussis	☐
Pneumococcal	☐	Polio	☐	Rotavirus	☐	Tetanus	☐		

Other: _____

Lifestyle:

Please indicate how often you partake in the following?
(check 'day' or 'week')

Caffeine: _____ ☐day ☐week
Alcohol: _____ ☐day ☐week
Cigarettes: _____ ☐day ☐week
Marijuana: _____ ☐day ☐week
Other recreational drugs: _____ ☐day ☐week

How often do you exercise weekly? ◯1 ◯2 ◯3 ◯4 ◯5+
Type of exercise: _____
Average duration of exercise: _____

Family Medical History: *Select YES (Y) if anyone in your IMMEDIATE family was diagnosed with any of the following conditions:*

Alcoholism	☐YES	Allergies	☐YES	Anemia	☐YES	Angina	☐YES
Anxiety	☐YES	Arrhythmia	☐YES	Arthritis	☐YES	Asthma	☐YES
Cancer	☐YES	Celiac Disease	☐YES	Colitis	☐YES	Crohn's Disease	☐YES
Depression	☐YES	Diabetes	☐YES	Eating Disorder	☐YES	Eczema	☐YES
Edema	☐YES	Emphysema	☐YES	Epilepsy	☐YES	Glaucoma	☐YES
Heart Attack	☐YES	Heart Disease	☐YES	Heart Murmur	☐YES	High/Low BP	☐YES
Infertility	☐YES	Kidney Disease	☐YES	Kidney Stones	☐YES	Liver Disease	☐YES
Multiple Sclerosis	☐YES	Osteoporosis	☐YES	Pancreatitis	☐YES	PMS	☐YES
Polyps	☐YES	Psoriasis	☐YES	Sleep Apnea	☐YES	Stroke	☐YES
Substance Abuse	☐YES	Thyroid Disease	☐YES	Ulcers	☐YES	Uterine Fibroids	☐YES

Other: _____

PROTECTION OF PERSONAL HEALTH INFORMATION:

Our clinic understands the importance of protecting your personal information. Our privacy protocols comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards and guidelines from the College of Naturopathic Physicians of British Columbia (CNPBC).

Your personal information is kept strictly confidential and is part of your medical record in our clinic. There are rare circumstances that require us to disclose information from your file. This is only limited to a request to access your file by the regulatory authorities mandated by law and/or authorized by you. For any other type of disclosure, we require a consent form signed by you. Our office will not, under any circumstances, disclose any of your personal confidential information to insurance companies.

_____ _____

Patient or Legal Guardian Signature Date (mmm/dd/yyyy)

PAYMENT POLICY

A current credit card is required to be kept on file to minimize contact with the front desk staff. This also ensures timely processing of payments for all virtual and phone visits. Receipts and other documentation will be emailed to all patients at the end of their appointment. All appointment fees are due upon rendering of services. This includes Naturopathic appointments, VEGA testing, Acupuncture sessions, and laboratory fees.

We accept payment by cash, Debit, Visa, MasterCard, and *E-transfer.

Any late payments past due by 30 days are subject to a 2% per month monthly interest accrual fee until balance is paid in full.

*All e-transfer payments for appointment fees must be received PRIOR to your scheduled appointment time. If this is your preferred method of payment, please discuss this with clinic staff at the time of booking.

FEE SCHEDULE

In Person, Telemedicine, and Phone Consultations	**Fee Amount**
Initial Consultation (50 minutes) *In Person or Telemedicine only*	$ 195.00
Extended Subsequent Consultation (up to 45 minutes)	$ 150.00
Subsequent Consultation (25 minutes)	$ 95.00
Mini Subsequent Consultation (10 minutes)	$ 65.00
Physical Consultation (25 minutes) *Existing patients only*	$ 105.00
Acupuncture (25 to 40 minutes) *Existing patients only*	$ 95.00
ACUTE Initial Consultation (up to 30 minutes) **At the doctor's discretion*	$ 105.00

In House Treatments and Lab Work *(in addition to consultation fee)*	**Fee Amount**
B12 Intramuscular Injection	$ 15.50
Glutathione Intravenous Injection, 1cc	$ 37.50
Glutathione, each additional 1cc	$ 8.15
In-House Urinalysis	$ 20.00
Myers Intravenous Push, 30cc	$ 65.00
Vega Electrodermal Screening (varies, call clinic for more information)	$ 50.00 - $ 140.00

LATE & MISSED APPOINTMENT CANCELLATION POLICY

Your appointment time is confirmed and reserved just for you! We understand unforeseeable emergencies do occur. If an appointment is missed or broken in less than 48-hours or no notice is given, we'll simply note it on your account and send you a reminder of the cancellation policy.

However, if a second missed appointment/late cancellation occurs, you will be subject to a cancellation fee equal to the cost of your scheduled appointment(s). Your account must be paid in full prior to booking further appointments, and our 2% per month monthly interest accrual fee will apply. Any subsequent missed appointment/late cancellations after this will result in immediate billing of the cancellation fee equal to the cost of your scheduled appointment(s) to the credit card on file. An invoice will be sent to you with a detailed explanation of the billed cancellation fees.

_____

Initials acknowledging *Cancellation Policy*

SUPPLEMENT RETURN POLICY

Unopened supplements that do not require refrigeration may be returned within 30 days of purchase. All opened and customized products are final sale, and no refunds or credits will be given. Custom products include but are not limited to botanical tinctures, creams, homeopathic remedies, botanical powders, and phenolics. You will be advised at the time of purchase if an item is final sale.

LABORATORY FEE RETURN POLICY

Uncompleted labs are eligible for in-house credit within 90 days of purchase, or a refund within 30 days of purchase. Patients must provide the original receipt and return the original lab requisition form(s) and lab kit(s) to the clinic for a credit to be issued.

Patients are responsible for following specimen collection instructions for at home tests. Please contact the clinic with any questions you may have prior to collection, as there are no credits or refunds for user error. Labs are non-transferable.

USE OF EMAIL CORRESPONDENCE

Our clinic offers patients the opportunity to communicate via email. Transmitting patient information poses several risks of which patients must be aware. Patients should not agree to communicate with the clinic staff via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- Security and privacy of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the identity of the sender or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the doctor or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in the cloud.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.

CONDITIONS OF USING EMAIL

Our clinic will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, our clinic and its doctors cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct. Consent to the use of email includes agreement with the following conditions:

- While our clinic will endeavor to respond promptly to email correspondence, email should never be used for medical emergencies or other time-sensitive matters. We will strive to respond to email enquiries within 24 hours on regular business days. Our clinic will not initiate email correspondence to patients.
- Emails to or from the patient concerning laboratory results, supplement enquiries, and treatment will be printed in full and made part of the patient's medical record. Because they become part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- As necessary, clinic staff may forward emails internally for healthcare operations, and other handling. The clinic will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Email communication is not an appropriate substitute for clinical visits, examinations, or treatment. The patient is responsible for scheduling appointments when required.

- If a patient's email invites a response from the doctor, a flat fee of $30 may apply. This fee is billed at the doctor's discretion and will be applied to your account and charged to the credit card on file.
- If a patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email.
- The clinic and its doctors are not responsible for information loss due to technical failures.
- It is the patient's responsibility to inform clinic staff of any changes to their contact information.

PATIENT CONSENT AND AGREEMENT

Naturopathic medicine is founded on the belief that the body has the innate ability to heal itself. Naturopathic doctors combine the wisdom of nature with the rigours of modern science. Naturopathic doctors look at more than symptoms; we seek to identify the underlying cause of the symptoms. Naturopathic doctors assess the whole person and consider the physical, mental, and emotional aspects of wellness and disease. Gentle, non-invasive techniques are often used to stimulate the body's ability to heal itself. The following are some of the approaches that may be used: physical examination and diagnostic assessment; ordering and interpreting labs; nutrition, diet, and lifestyle counselling; botanical medicine; homeopathy; professional quality supplement recommendations, and naturopathic physical manipulation.

Naturopathic doctors take a thorough case history, complete a screening and complaint oriented physical exam as needed, and may collect urine and/or blood samples for diagnostic purposes.

It is very important that you inform your naturopathic doctor of any existing health conditions and provide a complete list of medications and supplements, including all over-the-counter products you may be taking. Additionally, it is important to advise your naturopathic doctor if you are pregnant, suspect you may be pregnant, are planning to become pregnant, and/or are actively breastfeeding.

Some health risks associated with naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reaction to supplements and/or herbs, and mild discomfort or bruising from acupuncture, intravenous, and/or intramuscular injections. Your naturopathic doctor will explain to you any risks of adverse effects and advise you, as well as answer any questions you may have, to the best of their knowledge and ability. Results are not guaranteed and differ from person to person.

As a patient, you must be aware that naturopathic treatment and conventional medical treatment are not mutually exclusive, and therefore, you are free to seek or continue medical care from a qualified medical doctor. You must communicate any intentions to discontinue any prescribed pharmacological agents (medications) to your medical doctor and your pharmacist.

By signing below, you agree with the following:

a. I hereby request and consent to services rendered, and treatment provided by the doctors at Althea Wellness Centre, Inc.
b. I recognize that they are board certified Naturopathic Doctors registered by the College of Naturopathic Physicians of British Columbia.
c. I have the right to consent or refuse any treatment that I am uncomfortable with.
d. The doctors have the right to treat me within the scope of their practice and the right to refuse treatment.
e. The doctors may make referrals to outside practitioners if they feel it may be beneficial to my health care goals.

_____ _____

Patient or Legal Guardian Signature Date (mmm/dd/yyyy)