

# CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

## Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Privacy and protecting of your personal information is an important part and consideration of naturopathic doctors. This privacy policy outlines what your naturopathic doctor does to ensure that:

- Only necessary information is collected about you
- Information is only shared with your consent
- Storage, retention and destruction of personal information complies with existing legislative protection protocols (including electronic medical records that are housed within Canada and are compliant with such legislation and privacy protocols)
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body

Your naturopathic doctor is committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To access your health concerns, and advise you of your treatment options
- To communicate with you and remind you of upcoming appointments
- To communicate with all other healthcare providers on your healthcare team
- To allow us to efficiently follow up for treatment, care, and billing
- To invoice for goods and services, process payments and collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to hard themselves or others
- To be used for educational and research purposes (this includes case summaries and reports, unidentifiable photographs, lab results, and other pertinent medical information). Your identity will be protected at all times and any identifying information will be altered to protect your privacy in all above instances

**Patient Consent:** I \_\_\_\_\_ have reviewed the above information that explains how my naturopathic doctor will use my personal information and the steps that are taken to protect my information. I agree that my naturopathic doctor can collect, use, and disclose personal information about my case as set out by the above regarding privacy policies. I also understand that in order to be able to provide the best care for me, I welcome professional dialogue regarding my case between members of my medical team at the Dundas Chiropractic Centre.

**Signature of Patient or Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

# INFORMED CONSENT TO NATUROPATHIC TREATMENT

(THIS FORMED MUST BE SIGNED *PRIOR* TO THE INITIAL VISIT)

Naturopathic medicine aims to identify, treat, and prevent the of the cause of illness in an individual. By connecting the physical, mental, emotional, and spiritual needs of a person, a naturopath can create individualized treatment for patients. With a focus on overall health and wellness, naturopathic medicine employs the body's innate ability to heal itself. Naturopathy encompasses modalities such as (and not limited to) lifestyle counselling, nutrition, botanical medicine, traditional Chinese medicine, physical medicine, and homeopathy, to provide specific and individualized whole care to the patient. The naturopathic doctor will conduct a thorough case history, perform a focused physical examination, and order any laboratory testing that may be required.

Please advise your naturopathic doctor if you are **pregnant, suspect you are pregnant, or breast-feeding**.

The therapies are gentle and non-invasive however there are some risks associated with naturopathic medical treatments. Some symptoms may include, but are not limited to:

- Aggravation of a past or pre-existing symptom;
- Allergic reactions to herbs or supplements
- Fainting or bruising to the skin with acupuncture needle

As a patient you will receive information about your diagnosis/ or treatment, alternative course of action, any costs, expectation of desired effects, and any consequence of not having a diagnosis/or treatment.

I understand:

... that a confidential electronic medical record will be kept of the health services provided to me. I understand that I may request a copy of my record by paying the appropriate fee.

... the risks associated with my individualized treatment and services provided to me. I understand that results are not guaranteed and I do not expect Dr. Anousha Usman to be able to anticipate and explain all risks and complications.

I recognize that this consent form covers the entire course of treatment for my present condition with Dr. Anousha Usman. I understand that I am free to withdraw my consent and to discontinue participation from this service at any time.

I have read this statement and agree to work within its guidelines.

Patient Name (please print): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Naturopathic Doctor: \_\_\_\_\_