purewellness group

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Injection Therapy Health Screening Form

All of your answers will be held ***absolutely confidential***. If you have any questions, please ask. Thank you!

GENERAL INFORMATION

Date:

Name:

Date of Birth: Gender:

Address:

Home Phone: Work Phone:

Cell Phone: E-mail Address:

Occupation:

How did you hear about us?

Family Physician: Phone:

Other Health Care Providers: Phone:

MEDICAL HISTORY

Please list current medications and/or supplements:

Type	Dose and Date Started	Taken for

Surgeries / Injuries:

Date:

Date:

MEDICAL TESTING

Please list any preventative or exploratory tests that have been completed in the last five years (colonoscopy, cardiac stress test, blood work, ultrasounds, etc):

Type of Test	Result

Please list ALL allergies / sensitivities (food, medical, environmental, etc):

CARDIOVASCULAR

- ( ) High Blood pressure *
- ( ) Congestive Heart Failure *
- ( ) Heart Attack *
- ( ) Arrhythmia*
- ( ) Pacemaker or device *
- ( ) Heart Disease *
- ( ) Stroke *
- ( ) Bleeding disorder *
- ( ) _____

RESPIRATORY

- ( ) Chronic cough
- ( ) Shortness of Breath
- ( ) Bronchitis
- ( ) Asthma
- ( ) Emphysema *
- ( ) _____

ACHES AND PAINS

- ( ) Please describe

GASTROINTESTINAL

- ( ) Chronic Diarrhea
- ( ) Chronic Constipation
- ( ) Celiac Disease
- ( ) Inflammatory Bowel Disease
- ( ) _____

OTHER CONDITIONS

- ( ) Mental Illness *
- ( ) Skin Conditions
- ( ) Cancer *
- ( ) Epilepsy *
- ( ) Eating Disorder
- ( ) Arthritis
- ( ) Diabetes *
- ( ) Low Blood Sugar
- ( ) Headaches
- ( ) Eye/Vision Problems
- ( ) Ear/Hearing Problems
- ( ) Osteoporosis / Osteopenia
- ( ) Joint replacement / pins / wires
- ( )

IMMUNE

- ( ) Autoimmune Disease
- ( ) Infectious / Contagious diseases: *
- ( )

RENAL AND UROLOGY CONCERNS

- ( ) Kidney Disease
- ( ) Kidney Stones
- ( ) Urinary/Bladder Infections
- ( ) Interstitial Cystitis
- ( )

FAMILY HISTORY

- ( ) Autoimmune Disease
- ( ) Cancer
- ( )

PREGNANCY

- ( ) Due Date:

* If you have any of these conditions currently or in the past, you may not be eligible to receive Injection therapy without further testing or a full initial consultation with one of our Naturopathic Doctors.

FEE STRUCTURE FOR NATUROPATHIC VISITS

Full Initial visit: **$300**

60 minute visit **$230**

45 minute visit: **$175**

30 minute visit: **$125**

15 minute visit: **$75**

*Note: **Telephone and email consults** are also available and are subject to a fee based on time or service provided.

INFORMED CONSENT FOR INTRAVENOUS OR INJECTION THERAPY

We would like to take this opportunity to welcome you to Pure Wellness Group. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's natural ability to heal and improve the quality of life and health through natural means.

1. You have the right to be informed of the procedures and these procedures are not performed unless you have hadan opportunity to receive such information and to give your informed consent.

    a. The procedure involves inserting a needle into your vein or muscle and injecting the formula chosen for you by the Naturopathic Doctor
    b. Alternatives to Intravenous or Injection therapy are oral supplementation and/or dietary and lifestyle changes
    c. Risk of Intravenous or Injection Therapy include:
        i discomfort, bruising, and pain at the site of the injection
        ii inflammation of the vein used for injection
        iii severe allergic reaction, cardiac arrest and death
    d. Benefits of Intravenous or Injection Therapy include:
        i injectables are not affected by digestive insufficiency or disease
        ii total amount of infusion available to body tissues is high
        iii higher doses of nutrients can be given without the side effects that can occur with oral supplementation

2. You have the right to consent to or refuse any proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent for the Intravenous or Injection procedure(s) with any modifications to the procedures which, in the opinion of the presiding Naturopathic Doctor, may be indicated.

3. The procedure will be prescribed and performed by or under the direction of the Naturopathic Doctor named above with qualified medical assistants.
4. Additionally, I am aware of the clinic's policy for missed or cancelled appointments.

Should I cancel or wish to change a previously scheduled appointment without providing a **MINIMUM of ONE week-day** advance notice, I authorize you to bill my credit card on file for 50% of the published costs for the previously scheduled appointment.

Should I NOT show up for an appointment without providing ANY advance notice, I authorize **Pure Wellness Group** to bill my credit card on file for 100% of the published costs for the previously scheduled appointment.

Your credit card number will be collected at the time of scheduling the initial appointment and will ONLY be processed in the case of a missed appointment.

When you attend any scheduled appointment, you may pay with any form of payment of your choosing.

Please be advised that the above fee schedule is subject to change.

Pure Wellness Group will advise patients of price changes if and when they occur.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing
b. The procedure(s) set forth above has been adequately explained to you by the Naturopathic Doctor or medical assistant
c. You have received all the information and explanation you desire concerning the procedure
d. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.
e. You authorize and consent to the performance of the procedure(s)

I (print your name) _____ , acknowledge that as a new patient of the clinic, have read the information included herein, and understand that the form of medical care is based within the Naturopathic Medicine principles and practices. I under-stand that my ND or Nurse will answer any questions I have to the best of his/her ability. I understand that the results are not guaranteed.

I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and/or supplements I am currently taking (prescription and over the counter), or was previously taking. I have also advised my practitioner of the possibility that I may be pregnant and will continue to do so.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.

With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments outlined above except the following (list any therapies you do not wish to participate in): _____

I understand that **Pure Wellness Group does not provide refunds** for services, treatments or supplements. While our policy is firm, we will do everything we can to work with you to make your experience with us as positive as possible.

_____ _____

Patient's signature Date

_____ _____

Witness's signature Date

( ) I would like sign up for **Pure Wellness Group** newsletters and updates

E-mail address : _____

PATIENT INFORMATION AND PRIVACY FORM:

Privacy of your personal information is an important part of our office's pledge to provide you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

Our Privacy Information Officer is Dr. Tara O'Brien ND. Tara will attempt to answer any questions or concerns that you might have. Tara can be reached at the address and phone number above, or by email at: **reception@purewg.ca**. If you do have a concern and/or wish to make a complaint to us about our privacy policies, you must make your request in writing. Our Privacy Officer will promptly acknowledge receipt of your complaint in writing, and will ensure it is investigated thoroughly. You will be provided with a formal response in writing indicating any decisions/actions, and the reason for such.

If you are dissatisfied with the actions or decisions, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information below.

Privacy Commissioner of Canada
112 Kent St, Ottawa, ON K1A 1H3
Phone: 1-800-282-1376
Fax: 613-947-6850

Our privacy policies and procedures comply with the federal legislation called the Personal Information and Electronic Documents Act (PIPEDA). This very complex law does provide for some exceptions to the privacy principles that are too detailed to outline here.

Our Privacy Code sets out the offices' commitment to protecting your private health and personal information. It is available by request from any of our office staff.

Please be assured that every staff member in our office is committed to ensuring that you receive the best quality care. As such, 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 all trained in the appropriate uses and protection of your information.

We ask that you review our Privacy Code, for details on what our office 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 office will not under any circumstance directly supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent to use or disclose your personal information by written notification, and we will explain the ramifications of that decision, and the process. If a new purpose arises for the use/or disclosure of your personal information, we will seek your approval in advance.

Statement of Consent to Collect Information:

I have read and understood the above information, and am fully aware of the privacy policies of **Pure Wellness Group** how your office will use, collect and disclose my personal information, and the steps your office is taking to protect my information. I agree that **Pure Wellness Group** can collect, use, and disclose personal information about myself, as set out above and according to the PIPEDA guidelines.

Patient's signature	Date
Witness's signature	Date

PATIENT PLEDGE

Your health and healing depend on our commitment to doing the best that we can as your Naturopathic Doctor, in addition to YOUR commitment to the following:

- **A Partnership and a Process**
  Remember that your health concerns probably did not develop overnight. Most health concerns develop insidiously over months or years. In the same fashion, some chronic illness can take weeks, months, or even longer to improve with regular treatment. If you do not see immediate results, do not be discouraged, and most certainly do not give up. It takes time, patience and persistence to find and treat the root causes of your illness. You will be expected to put in as much effort as possible, and we will do the same.

- **Prescribed changes**
  Your compliance with prescribed dietary changes, supplements, botanicals, parenteral therapy, medications, as well as other treatment recommendations is really the key to healing. If you do not follow the recommended treatment plan with diligence and consistency, your journey towards optimal wellness will be slowed.

- **Patient/Physician Commitment**
  Establishing and maintaining a healthy and effective relationship with your physician at **Pure Wellness Group** is a key component to your success as a patient. Once a treatment plan is established, it is important that you remain in your Naturopathic Doctor's care and stay in regular communication.

- **Ongoing Support**
  Naturopathic Medicine is a unique approach from the existing health-care model in Canada. Chronic illness can contribute to significant changes in your activities of daily living, in your energy, mood, or focus. Some of the changes that your Naturopathic doctor suggests may be overwhelming at times. We suggest that patients find a source of support in their social network (family, friends, or colleagues). If you do not feel that you have this support in your immediate social group, we recommend that you find professional help in the form of a Counselor, Psychotherapist, or a Life Coach.

I have read and agree to the statements above.

Patient's signature	Date
Witness's signature	Date