revivelife™
your path to wellness

Health Consent Form

Name:______________________________ Date:_______________________ Date of Birth:_______________________

Address:_____________________________City:____________________Prov:_______Postal Code:_______________

Phone: (H)____________________ (W)________________________ Email:_____________________________________

Person to Notify in Case of an Accident or Emergency:
Name:____Phone:______________________________

Referred by/Heard about through:____

Each Patient is required to read and sign this form before treatment. Your signature acknowledges the following:

1. I understand that Naturopathic Medicine is not covered by Provincial government or Ontario OHIP, yet Naturopathic expenses may be covered by private insurance plans and may be tax deductible.
2. The fees and services have been clarified in advance; Payment is due at the end of each visit by credit card, pay direct or cheque. Interest will be charged on overdue accounts 10% per month.
3. Our policy is an invoice of 50% of your scheduled visit fee for visits changed or cancelled less than 48 hours in advance. This time has been reserved for you and if left open means someone in waiting cannot take the opening.
4. Our dispensary is to provide high quality products at a convenient location. The products recommended may be purchased at any location that you choose. Our policy is that if you find a product available for less than the price we offer; we are happy to price match.
5. I understand that natural health care is a joint responsibility between me (the patient) and the practitioner. Improving my lifestyle can be as important as the remedies and the treatment.
6. My health records may be used in research providing that my name not be revealed. At all other times my health records will be held in the strictest of confidence.
7. I realize that Naturopathic Medicine is not an isolated system and that our Naturopaths welcome teamwork with MD's, DC's and other practitioners.
8. The decision to discontinue drugs or any other prescribed medical treatment is my own responsibility. If I forgo standard medical treatment in favour of natural healing, I assume all responsibility for any potential risk that may entail. Our Naturopaths will explain procedures, predicted outcomes and risks in advance.
9. I am aware that appointments that run over scheduled time will be charged the difference in 15 minute increments.
10. When adding my email address I am agreeing to receive the Revivelife newsletter and clinic information. If I decide that I do not wish to receive the newsletter or continue receiving information it is my responsibility to contact the office 613-829-7100 to remove my email address from the Revivelife systems.
11. The Revivelife Clinic uses the vega test as a supportive technique (not a diagnostic or treatment device) used in conjunction with an individual's history, physical findings and or laboratory tests. The information gathered is used in conjunction with the traditional elimination challenge technique to determine a person's food sensitivities. The vega test along with a patient's history will facilitate food sensitivity assessment which is to be noted different then food allergy detection. If a person has other allergies it is important for them to overlap these results with any food sensitivities that are determined.

Signed:____ Date:_______________________________