revivelife™
your path to wellness

Health Consent Form (updated 3,15,18)

Name: ____ **Date:** ____

Phone: ***(H)***___________________ ***(W)***______________________ **Address:** ____

City:______________________ **Prov:**__________ **Postal Code:**________________ **Date of Birth:** ________________________________

Email:__________________________ **Insurance Company:** ____

Person to Notify in Case of an Accident or Emergency: Name: ____ **Phone:** ______________________________________**Referred by/Heard about through:** ______________________________________

Each Patient is required to read, initial 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 interact, credit card or pay direct. *Interest will be charged on overdue accounts 10% per month.*
3. ____ I am aware that appointments that exceed scheduled time will be charged the difference in 15-minute increments.
4. ____ Our policy is an invoice of 100% of your scheduled visit fee for visits changed or cancelled less than 48 hours in advance. Programs and Hormone appointments cancellation fee is $175.
5. ____ Our pharmacy is to provide high quality products at a convenient location. The products recommended may be purchased at any location that you choose.
6. ____ I understand that natural health care is a joint responsibility between myself (the patient) and the practitioner. Improving my lifestyle is as important as the remedies and the treatment I receive.
7. ____ I understand that to provide me with integrative health care and services, the Revivelife Clinic will collect some personal information about me, including: personal data; address, phone number, email, billing information; medical history and treatment record. Access to information is permitted as follows: My primary care practitioner- all information which is deemed as “confidential” between the primary practitioner and you the patient which is to be released only upon your signed Consent to Release information form and the wellness/ administrative staff – address, phone number, email and billing information. I understand that I may review written or electronic information from RevIvelife and may be contacted by staff for recall/check up purposes from time to time. I have access to the Revivelife Clinic’s Privacy Policy on the website in regards to the Government Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask questions I have about the Privacy Policy and they have been answered to my satisfaction. I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. I agree to the RevIvelife Clinic collecting , using and disclosing personal information about me as set out in the RevIvelife Clinic’s Privacy Policy.
8. ____ I understand that a confidential record will be kept at Revivelife Clinic. 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. I understand when required, the Revivelife practitioner may discuss my case with other health professionals in order to provide integrative and continuous care. I understand that I may see my file at any time and may request a copy of my file at $0.15/page.
9. ____Clinical records are the property of the patient. RevIvelife is the custodian and by regulation the original file is required to remain at the facility. Transfer of a copy of clinical or financial information will occur with the individual’s written consent. Original documents are retained for seven years. A fee may be charged for retrieval, copying and distribution , payable by the patient.
10. ____ I realize that Naturopathic Medicine is not an isolated system and that our Naturopaths welcome teamwork with MD’s, DC’s and other practitioners.
11. ____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.
12. ____ When adding my email address, I am agreeing to receive the Revivelife newsletter and clinic information. If I decide I do not wish to receive the newsletter or continue receiving information, it is my responsibility to contact Revivelife to remove my email address from the Revivelife system.
13. ____ The Vega test along with a patient’s history will facilitate food intolerance assessment which is to be noted different then food allergy detection.
14. ____ I will disclose all allergies to my practitioner.
15. ____ I acknowledge and understand the risks and limitations of using electronic communication. I understand reasonable means will be used to protect the security and confidentiality of information received and sent. All electronic communications will be reviewed and responded to, though a guarantee cannot be made as to the time frame of the response. If I haven’t heard from a practitioner, I will contact Revivelife Clinic for follow up to ensure the communication has been received. I am to inform the practitioner of any information I do not want shared via electronic communication. The practitioner is not responsible for information lost due to technical failure associated with my software or internet service provider.
16. ____ I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the medical doctor, nurse practitioner or the MD/nurse practitioner’s staff using the services may not be encrypted. Despite this, I agree to communicate with the practitioner and/or Revivelife’s staff using these services with full understanding of the risk.
17. ____ I acknowledge that either I, or any of Revivelife’s practitioner may, at any time, withdraw the option of communicating electronically through the services upon providing written notice. Any questions I had have been answered.

Print Name: ________________________________ Date: ___________________ Signed:____

Witness Name: ________________________________ **Date** ________________ **Signed:** ____

POWER HORMONE PATIENTS- PLEASE TURN PAGE TO THE BACK.

320-2249 Carling Ave | Ottawa | K2B-7E9
phone: 613.829.7100 | fax: 613.829.2608
revivelife.ca | info@revivelife.ca

Power Hormone Patients Only

I give my consent to the administration of the above named BHRT treatment, integrative medicine, and lab tests as needed. My initials and signature acknowledges the following:

1. ____ I agree to a referral to ________________________ MD/Nurse Practitioner for BHRT care.
2. ____ I am aware my consultation will occur via telemedicine. A telemedicine consult is done through a two-way video link-up whereby the MD/nurse practitioner can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the health provider does not have the use of the other senses such as touch, or smell and it may not be equivalent to a face-to-face visit. I know there are potential risks with the use of this technology. These include but are not limited to interruption of the audio/video link, disconnection, a picture that is not clear enough to meet the needs of the consultation and electronic tampering. I can ask the telemedicine exam to be stopped at any time. I understand the technology preference used will be OTN (in that order) for Dr. Upadhyay and FaceTime®, Skype® or OTN (in that order) for the Nurse Practitioners and OTN, FaceTime®, Skype® or. Audio only or telephone consult will be used as a last resort.
3. ____ I am aware that an office visit is required a minimum of annually for continued BHRT care. I am also aware that the frequency of my visits is determined by my health and that when indicated extra visits may be recommended.
4. ____ Dr. ________________________________ MD/ND has discussed the following combination of Integrative Medicine and Bio-Identical (Natural) Hormone Replacement Therapy (BHRT) with me.
5. ____ I understand that bioidentical hormone replacement therapy (BHRT) is the therapeutic use of hormones identical to the hormones made by the human body. While these hormones are generally used to treat PMS, perimenopause, menopause, andropause, thyroid dysfunction and adrenal fatigue, other symptoms of chronic disease can also be addressed.
6. ____ It is my responsibility to have an annual exam, PAP and breast exam according to Ontario guidelines for women, or PSA/rectal exam as per Ontario guidelines for men.
7. ____ I will have recommended labs and imaging required to ensure I have no disease(s) that would make BHRT inappropriate.
8. ____ I understand there is no guarantee to treatment. I further understand that lifestyle modification, nutrition, weight management, adequate sleep and stress reduction are important factors to the success of BHRT.
9. ____ As required, I will maintain my family MD and any specialists that are in my health care team.
10. ____ BHRT prescriptions are filled for three months at a time. In order to refill a prescription, a **VISIT** and blood work to review your health must take place. **Refills cannot be filled over the phone or by email.** Please call to schedule your appointment allowing a minimum of **3 WEEKS** to fill your prescription once you have had your appointment. We recommend having an appointment 4 weeks before your prescription runs out, as each prescription renewal will require new blood work.
11. ____ If you have any questions concerning your proposed treatment, ask your physician/nurse practitioner before signing this consent form.

Patient's Consent

I have read and fully understand this consent form and realize my Bio-Identical Hormone Replacement Treatment, hormone lab tests, prescriptions, supplements & vitamins and the physician's time and consultations with me, and any future consultations are all fee-based & **I agree to pay the fee at the time of each session.**

ALL APPOINTMENTS ARE PAID AT THE TIME OF THE BOOKING BY CREDIT CARD

These services are **NOT** covered by OHIP. Some insurance companies may reimburse a portion of my care, and it is my responsibility to consider what my insurance covers, and to submit receipts to said insurance for possible reimbursement. I agree to pay by cash, Interac or credit card at the time of my visit. A credit card must be kept on file for all BHRT patients.

(Revivelife does **NOT** accept cheques and we do **NOT** invoice or bill patients.)

I give my consent to the administration of the above named BHRT treatment, integrative medicine, and lab tests as needed.

Print Name: ______________________________ Date: __________________ Signed:____

OHIP #: ____