Declaration and Consent to Treatment

Patient's Name:____

1. This is to acknowledge that I have been informed and I understand that:

a. Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment or advice that I may be receiving or may not be receiving or may in the future receive from another health care provider.
b. I am at liberty to seek or continue medical care from a medical doctor or other health care providers licensed to practice in Ontario.
c. No employee, agent, board member, instructor or anyone else under the Clinic's direction or control has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
d. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care providers.
2. I declare that I have received a full and complete explanation of the treatment and/or services that I will receive at the Clinic and hereby authorize and consent to treatment by the Clinic.
3. I acknowledge the following fee structure:

<u>Fees below include taxes.</u>

First Visit and Assessment 1.5 hrs	$ 180
Fertility Program First Visit 2 hrs	$ 220
Children under 18 years old(first visit) 1hr	$ 130
Follow-up Visits (adult or child) 30 minutes	$ 75
Acupuncture Treatment 30 minutes	$ 75

Telephone Consultation 5-15mins (you must be a patient of the clinic):
Billed for time at $75 per half hour minimun of $25.

Supplements, remedies, laboratory tests and other fees cost extra and are not included in the visit fee. These fees do not include taxes.

A 24-hour notice of cancellation must be given or else the full visit fee will be charged. This will be strictly enforced! Please give 48 hours of cancellation for Saturday or evening appts.

4. I agree to pay my full account at the time of each visit or treatment.
5. The substance or devices prescribed by your Doctor of Naturopathic Medicine may be purchased from your Doctor of Naturopathic Medicine, a Pharmacy, A Health Store, or a Medical supply company of your choice.

Date: ________________________________

Patient's Signature ________________________________

Naturopathic Doctor's Signature ________________________________