collective HEALTHCLINIC

Your First Appointment

Congratulations on booking your first appointment! Here are a few reminders to get you prepared for your visit.

- Please fill out your intake forms before arriving to the clinic
- If you are taking any medications or supplements, please bring them to the clinic with you for your appointment
- Plan on being at the office for approximately 1 hour
- If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. Each patient is allocated 1 hour of time in the schedule; last minute cancellations or missed appointments will be invoiced.

Get Connected!

- Check out our website at www.collectivehc.ca where you can learn more about our services and sign up to receive our n
- Follow us on Facebook or on Twitter

I look forward to working together on your health goals!

Yours in health,

Dr. Faith Flatt, B.A., R.N.C., N.D.

Dear New Patient,

I look forward to meeting you on our first appointment. Please complete the intake forms enclosed in this package prior to our first visit together. It is important that you fill out the forms completely and accurately so that our first meeting can be as productive as possible. All answers are strictly confidential.

Your first visit will be spent going over your health concerns and will include a relevant physical exam. During this initial consultation, I will collect the information required to make an assessment of your situation. In most cases, some form of initial treatment will be implemented at this time. This may include any combination of dietary recommendations, lifestyle changes, herbs, Chinese medicine, acupuncture, homeopathic remedies, or supplements. Your complete treatment protocol will be established at your first follow-up visit as this allows me time to gather any testing or imaging I may need, as well as make sure your protocol meets the most current research standards. Subsequent visits will be booked as to review your progress and make appropriate changes to your program.

Payment for appointments is required at the end of each visit. While OHIP does not cover Naturopathic services, many private insurance policies offer partial or complete coverage. Official receipts will be issued at the end of each visit so that you may be reimbursed directly by your insurance company.

Some supplements that are prescribed can be purchased from my online clinic dispensary. Every effort has been made to ensure that all products are of the highest quality and reasonable cost. However, you are welcome to purchase your supplements elsewhere.

I am looking forward to meeting you and moving forward together in your health.

Dr. Faith Flatt, B.A., R.N.C., N.D.

collective HEALTHCLINIC

New Patient Intake Form

Please fill out forms to the best of your ability and bring completed forms with you to initial consultation. If you have any recent medical test results that are relevant, please bring them along to your appointment. Also, please bring any supplements and/or medications you are currently taking.

Contact Information:

Full Name: _____Date: _____
Address: _____ City: _____
Province: _____ Postal Code:_____
Telephone: Home (___)_____ Work (____)_____
Mobile (____)_____Other (____)_____
Email Address:_____

Date of Birth: _____Age: _____ Gender: Male / Female
Marital Status:_____ Occupation:_____
Number of hours worked per week: _____

Name of Medical Doctor:_____
Telephone: (_____)_____Fax: (____)_____
Are you currently under his/her care? Yes / No
If yes, for what condition(s)?_____
Date of last physical:_____

How or by whom were you referred to this clinic?_____
Have been treated by a Naturopathic Doctor before?
If yes, by whom?_____ When?_____

In case of Emergency:
Contact:

_____
Full Name Relation

Telephone ( )_____

We will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, please indicate where it is appropriate to leave messages for you (**please check**):

Cell phone ☐ Home ☐ At work ☐ Never leave ☐

Current Health

What are your primary health concerns? List as many as you can, in the order of their importance to you. (Attach a separate sheet if necessary)

1) _____

2) _____

3) _____

How would you describe your general state of health? (Please circle)

Excellent Good Fair Poor

Do you have any allergies (environmental, medicines, food, etc.)?

_____

_____

_____

_____

Are you currently taking any medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc)? Please list name, dosage, and what you are taking it for:

_____

_____

_____

_____

_____

_____

General Information

Height: ____ Weight: ____ Weight 1 yr ago: ____

Maximum weight:_____ When: ____

What time of day is your energy and alertness best? _____ Worst? _____

Primary interests and hobbies: _____

Primary form of exercise, if any: _____

How often?_____

Please list any **significant** medical history (this may include major illnesses, surgeries, traumas, etc):

_____
_____
_____
_____
_____
_____
_____
_____

Indicate if a close relative (parent, child, sibling) has any of the following:
Allergies –
Asthma –
Heart Disease –
High blood pressure –
Cancer –
Diabetes –
Mental Illness –
Drug Abuse/Alcoholism –
Kidney disease –
Other -

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____
_____
_____
_____

Is there anything that has not been asked that you feel is important?

_____
_____
_____
_____

Patient Consent To Treatment, Privacy Policy, and 24 Hour Cancellation Policy

It is important to understand that there are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential in accordance with the provincial laws and will not be released to others unless so directed by myself unless law requires it.

If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers.

I understand that I may look at my medical record at anytime and can request a copy of the file by paying the appropriate fee.

I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that Dr. Faith Flatt, B.A., R.N.C., N.D. and Collective Health Clinic will take all necessary steps to provide adequate privacy of all my medical records.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue my participation at any time.

24 Hour Cancellation Policy

Dr. Faith Flatt, B.A., R.N.C., N.D. takes pride in the quality of care she offers her patients. In order to do this she has a strict cancellation policy. Dr. Faith Flatt, B.A., R.N.C., N.D. requires a 24 hour cancellation notice prior to your appointment time. If this sufficient time is not given, you will be invoiced for the full amount of the missed appointment .

Non: Sufficient Funds (NSF) Cheques

Please note that there will be a $20.00 charge on each NSF cheque.

Patient Consent

I have reviewed the above information that explains common health risks, but not limited to as described above, with use of Naturopathic Medicine. I have also reviewed the above information that explains how Dr. Faith Flatt, B.A., R.N.C., N.D. will use my personal information, and the steps Dr. Faith Flatt, B.A., R.N.C., N.D. will take to protect my information. I agree that Dr. Faith Flatt, B.A., R.N.C., N.D. can collect, use and disclose personal information about_____**(Print name)** as set out above in the information about the Clinic's privacy policy. I have reviewed and understand the 24 hour cancellation policy and will accept paying the full fee for the appointment if appropriate time is not provided.

Signature:_____ Date:_____

Agreement for Receipt of Services

Naturopathic Service Fees

Adult Intake (12 years age or more; 1 hr.) = $165
Pediatric Intake (Under 12 years age; 1 hr.) = $135
Follow-up Appointment (12 years age or more; 30 min.) = $82.50
Follow-up Appointment pediatric (Under 12 years age; 30 min.) = $67.50

Acupuncture follow-up Appointment (45 min.) = $90

**Appointment fees are tax exempt.

B12 injection: $20 each (plus H.S.T.)
IgG Allergy test: $280.00
Salivary Hormone Testing: price varies depending on tests run
Bloodwork: price varies depending on tests run

Facial Rejuvenation Acupuncture
Initial Consult (1.5 hrs.)= $175.00
Follow up (1 hr.)= $150.00

I have seen and agree with the fee structure for the services offered by Dr. Faith Flatt, B.A., R.N.C., N.D. I understand that payment in full is expected following each treatment session.

_____ _____
Patient/Parent or Guardian Date

If you require special documentation for insurance purposes, please feel free to ask the receptionist.