
PATIENT CONSENT FORM FOR COLLECTION USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is critical while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information in accordance to Ontario legislation set under the Registered Health Professionals Act.

Dr. Romi Raina, ND will be the only one coming in contact with your personal information and is fully aware of the sensitive nature of the information that you have disclosed. He is trained in the appropriate use and protection of your information.

This privacy policy ensures:

- only necessary information is collected about you;
- will only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- these privacy protocols comply with privacy legislation and standards of our regulatory body, The College of Naturopaths of Ontario.

How Dr. Raina Collects, Uses and Discloses Patients' Personal Information

Dr. Raina understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

Dr. Raina will collect, use and disclose information about you for the following purposes:

- to assess your health concerns
- to provide health care
- to advise you of treatment options
- to establish and maintain contact with you
- to send you newsletters and other information mailings
- to remind you of upcoming appointments
- to communicate with other treating health-care providers when necessary
- to allow us to efficiently follow-up for treatment, care and billing
- to complete claims for insurance purposes
- to comply with legal and regulatory requirements of our regulatory body, the College of Naturopaths of Ontario acting under the authority of the Registered Health Professionals Act
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to comply with all regulatory requirements
- to comply generally with the law
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have reviewed the above information that explains how your Clinic will use my personal information, and the steps your Clinic is taking to protect my information. I agree that Dr. Romi Raina ND can collect, use and disclose personal information about _____ (Patient name) as set out above in the information about the Clinic's privacy policies.

Signature

Print name

Date

Signature of witness

Informed Consent to Naturopathic Diagnostic and Treatment Procedures

Patient Name	
Address	
Phone #	

Naturopathic doctors utilize non-invasive methods for assessment of bodily function and natural therapeutics for correction of imbalances. Naturopathic doctors (NDs) are not medical doctors (MDs) and utilize different modalities of treatment. Therefore, if standard medical treatment (drugs, surgery, etc.) is necessary, it must be obtained from a medical doctor.

Naturopathic treatment and standard medical treatment are not mutually exclusive and, as such, a patient is free to seek or continue medical care from a qualified physician.

Your signature is required before any treatment is rendered. Your signature acknowledges the following:

- You have read the above information and that you understand that you are ultimately responsible for your own health.
- Diagnosis, treatment and/or referral to other health care professionals are based upon the assessment of conditions revealed through personal history, interview, physical assessment and laboratory testing.
- You have been informed of, and understand the diagnostic and therapeutic procedures with respect to expected benefits, potential risks and side effects, the likely consequences of not having/following the procedure(s) and what alternative course(s) of action are available.
- You are accepting or rejecting this care of your own free will and choice.
- You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered (by the end of each visit), unless prior arrangements have been made.
- If you have any questions regarding your treatment program, you will call to clarify these issues.

I _____ (Patient's Name) hereby authorize and consent to Naturopathic treatment and examination by Dr. Romi Raina ND.

Please subscribe me to receive the clinic newsletter yes ___ no ___ initial: _____

Date signed _____

Patient's or Guardian's signature _____

Print Patient's or Guardian's name _____

Relationship to Guardian if patient is a minor _____