PATIENT CONSENT FORM
FOR COLLECTING, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Clinic. Protecting your personal information is important to us. We will be as open and transparent as possible about the way we collect, use and disclose your personal information. All staff members who come in contact with your personal information are aware of the sensitive nature of your personal information. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our Clinic is doing to ensure that:

- ☐ Only necessary information is collected about you;
- ☐ We only share your information with your consent;
- ☐ Storage, retention, and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- ☐ Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy-Naturopathy.

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our Clinic 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.

This Clinic 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 your upcoming appointments
- To communicate with other treating health care providers
- 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 Board of Directors of Drugless Therapy-Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services, process credit card payments, or collect payment
- To process credit card payments
- To assist this Clinic 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 practice sale

Patient Consent

By signing the consent section of the 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.
In this Clinic, ***Darlene Gustin ND*** acts as the Privacy Information Officer.
A copy of the Bronte Natural Health Clinic Privacy Policy is available on request.

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 ***Darlene Gustin ND*** can collect, use and disclose
Personal information about _____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 PROCEDURES

Patient Name:_____
Address:_____
City/Town:_____
Province:_____ Postal Code:_____
Phone:_____

Darlene Gustin BSC ND
2368 Lakeshore Road West
Oakville ON L6L 1H5
905-825-8787

RECOMMENDED DIAGNOSTIC PROCEDURE(S)
(including those by referral to another practitioner)

Appointments(consultations, physical examination)	$160/hour
Hair Analysis	$ 95.
Urine Analysis	$ 14.-$28. Variable
Common testing (Blood, stool, urine, saliva)	

RECOMMENDED THERAPEUTIC PROCEDURE(S) PLAN
(including those by referral to another practitioner)

- ☐ diet and lifestyle consultations
- ☐ herbs and supplements
- ☐ other _____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic procedure(s) and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent/withhold my informed consent for the recommended diagnostic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

X _____

Naturopathic Doctor **Patient or Lawful Representative**

_____

Witness Signature* Date Signed

Address:_____
Town/City:_____
Province:_____
Postal Code:_____
Phone No. _____
*__Witness Signature is advised but not necessary__