



## Health Consent Form

### Note to Client

*We want your informed consent. This means that we want you to understand the services we hope to provide to you and what we do with personal information we obtain about you as well as the costs of any of those services. If you have a question on any of this, please ask.*

### Consent For Treatment

I, \_\_\_\_\_ hereby consent to assessment and treatment by a Registered Physician / Registered Physiotherapist / Registered Chiropractor / Registered Massage Therapist/ Registered Dental Hygienist, Exercise Trainer or anyone working in this facility.

I have had an opportunity to discuss with the attending Registered Physician / Registered Physiotherapist / Registered Chiropractor / Registered Massage Therapist/ Registered Dental Hygienist, Exercise Trainer the nature (frequency & duration of each session, length of program) and purpose/goals of the service, the costs of those services and of the treatments / procedures that I may receive. I have been advised of the risks and benefits. I understand that the results are not guaranteed.

I understand that Drs Blenkarn and Balon, as owners of the clinic, have a financial interest in all services and products offered at the clinic.

### Consent For Personal Information

I understand that in order to assist in fully informed, personalized healthcare the Stittsville Integrative Medicine Centre has to collect both "personal information" about me and my "personal health information". The "personal health information" is governed in accordance with the Regulatory College requirements for which all health professionals and their staff comply. The "personal information" would include home and work telephone number, address, date of birth, OHIP number, and if applicable, WSIB claim number, Extended Health Benefits information, Casualty or LTD Insurance information.

I have been provided the opportunity to review the Stittsville Integrative Medicine Centre's Privacy 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 and have been given a chance to ask any questions about the Privacy Policies 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 Stittsville Integrative Medicine Centre's collecting, using and disclosing personal information about me as set out above and in the Stittsville Integrative Medicine Centre's Privacy Policy.

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**PRINTED NAME** \_\_\_\_\_