Cure Integrative Clinic
483 Dundas St W, Unit 207
Oakville, ON, L6M 1L9
Phone: 905 581 5856

# CONSENT FOR TREATMENT

I would like to take this opportunity to welcome you to the services of **Dr. Nesreen Hassan**, Naturopathic Doctor. This practice utilizes the principles of Naturopathic Medicine to assist the body's own ability to heal and thrive. A number of different approaches may be used: Functional Medicine, Clinical Nutrition and Nutritional supplements, Botanical/Herbal Medicine, Homeopathy, Traditional Chinese Medicine, Acupuncture, and Lifestyle Counselling.
The slight health risks of some Naturopathic treatments include, but are not limited to aggravation of pre-existing symptoms or conditions, allergic reaction to supplements or herbs and pain, fainting, bruising or injury from acupuncture, muscle strains and sprains from spinal manipulation.

Your practitioner will conduct a thorough case history. As part of a naturopathic intake assessment, a physical exam and/or specific laboratory tests (blood and/or urinary) may be required and used as part of the treatment work-up (as deemed necessary after a comprehensive intake).
Although Naturopathic Medicine uses very gentle therapies, even these may induce complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly and in certain conditions including but not limited to diabetes, liver, heart or kidney disease. It is therefore important to inform your Naturopathic Doctor of any illnesses you suffer from or medications you may be taking (prescription or over-the-counter).
**The slight health risks of some Naturopathic treatments include**, but are not limited to: aggravation of pre-existing symptoms or conditions, allergic reaction to supplements or herbs and pain, fainting, bruising or injury from acupuncture, muscle strains and sprains from spinal manipulation.

If you are a female and are pregnant, suspect you may be pregnant, or are nursing, please advise your Naturopathic Doctor immediately.

**PATIENTS ARE ENCOURAGED TO HAVE THEIR OWN FAMILY MEDICAL DOCTOR. Naturopathic medicine is complementary to but does not replace, the services of your medical doctor and specialists. Patients are encouraged to maintain all regular medical procedures, checkups and testing as suggested by your medical doctor.**

- As a patient of **Dr. Nesreen Hassan, ND**, I am at liberty to seek or continue medical care from a medical doctor or other health care provider. This consent form is intended to cover the entire course of treatment for my present condition.
- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
- I understand that to provide me with Naturopathic services, **Dr. Nesreen Hassan, N.D** will collect some personal information about me. For example; address, phone number, and health history.
- I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself; unless the law requires it.
- I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.



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- I understand that the Naturopathic Doctor will answer any questions I have to the best of her ability.
- I understand that the results are not guaranteed. With this knowledge, I voluntarily agree to the diagnostic and therapeutic treatments above.
- I understand that treatment advice will not be given over the phone or via e-mail unless directly relating to specifics discussed during a clinic visit.
- I accept full responsibility for any fees incurred during care and treatment
- I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment.
- I also understand that the **Cancellation policy** requires me to cancel and/or reschedule a booked appointment 24 hours prior to a given, scheduled appointment. Cancellations with less than 48 hours' notice will incur a charge of 50% of the scheduled visit fee as a cancellation fee.
- I would like to receive newsletters and other informational mailings from **Dr. Nesreen Hassan, ND and Cure Integrative Clinic Inc.**

**CONSENT FOR VIRTUAL CONSULTATION:**

We offer virtual consultations which involve the use of electronic communications to allow us to provide patient care. The virtual provision of our services allows us to use information gathered electronically for diagnosis, therapy, and follow-up and/or education. As with any medical procedure, there are potential risks associated with virtual consultations. We use our best efforts to ensure that your personal and confidential information is kept securely and our electronic systems will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**However, by agreeing to receive our services virtually you acknowledge and agree that:**

- I understand that my health care provider wishes me to engage in a phone or telemedicine consultation.
- I understand that phone and/or telemedicine consultation will not be the same as a direct patient/ health care provider visit due to the fact that I will not be in the same room as my health care provider.
- In rare cases, information transmitted may not be of sufficient quality to allow for appropriate therapeutic decision-making.
- Although all efforts have been made to ensure my privacy, I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
- I understand that delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
- I have had the alternatives to a phone/telemedicine consultation explained to me and in choosing to participate in a phone/telemedicine consultation I understand that some parts of the consultation involving physical tests/exams may need to be deferred until an in-person appointment can be conducted.
- I understand that in rare cases, security protocols could fail, causing your personal information to be accessed by third parties.



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- I understand that billing will occur from my practitioner/clinic for this service.
- I have had a direct conversation with my doctor, during which I had the opportunity to ask questions with regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
- We cannot guarantee the availability of virtual consultations which may become unavailable due to system backup procedures, Internet traffic volume, upgrades, overload of requests to the servers, general network failures or delays, or any other cause which may from time to time make our virtual services inaccessible to you.

**EMAIL CONSENT FORM:**

I hereby acknowledge that I have requested the opportunity to communicate by email. I understand that in communicating in this manner I am exposing myself to certain risks. These risks include:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and retain emails that pass through their systems.
- It is impossible to verify the true identity of the sender or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system and potentially damage or disrupt the computer.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or in cyberspace.
- If the patient's email requires or invites a response from the naturopathic doctor and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient is responsible for informing the naturopathic doctor of any type of information the patient does not want to be sent by email. The naturopathic doctor will use reasonable means to protect the security and confidentiality of email information sent and received; however, because of the risks just outlined,
- The naturopathic doctor cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct by its staff or student interns.
  Although the naturopathic doctor will endeavor to read and respond promptly to an email from a patient, the naturopathic doctor cannot guarantee that any particular email will be read and responded to within any particular period of time. Accordingly, patients should not use email for medical emergencies or other time-sensitive
  matters. Email communication is not an appropriate substitute for clinical examinations.
- Patient Acknowledgment and Agreement:
  I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication by email between my naturopathic doctor and me. I consent to communicate by email with my naturopathic doctor in spite of these risks. I have been given an opportunity to ask questions and any questions have been answered to my satisfaction.

**PAYMENT CONSENT FORM:**



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I hereby authorize Cure Integrative Clinic Inc. to charge my card using the information I provide upon booking my appointment. I understand that Cure Integrative Clinic Inc. may further charge my card for any unpaid or overdue balances. I understand that financial information shall be stored for future transaction reference for any payment processes.

**CANCELLATION OR NO-SHOW POLICY:**

This policy is in place in order to ensure patients who need care do not have to wait to get on our schedule in favor of a patient that does not show up. Canceling last minute or not arriving to your appointment is unfair to other patients in need, our business, and yourself. All cancellations need to be made 48 hours prior to your appointment. If you do not show up for your appointment or cancel within 48 hours, you will be responsible to pay 50% of the scheduled visit fee as a cancellation fee. In order to schedule the next session, you will need to pay in advance for the next session at the time of booking. If you cancel or no show a second time, we will retain the entire amount paid for that session.

**Transcribing App Consent**:

I understand that for accurate record-keeping, a secure, third-party app may be used to transcribe audio into written text. This service is employed solely for documenting my health information, and all transcripts are handled under the same privacy standards as my medical records. I also acknowledge that I may withdraw my consent for this service at any time by notifying the clinic in writing.

I acknowledge that I have been informed of, and fully understand the above.

**Name:** _____

**Signature:** _____ **Date:**_____