DRJENNIFERBAER.COM
75 ELLSWORTH AVE. TORONTO ONTARIO M6G 2K4
P 416-783-1800 F 647-346-7666

ND
NATUROPATHIC DOCTOR
DIGESTIVE HEALTH

Dear Patient/Guardian:

Thank you for your interest in the services of Dr. **Jennifer Baer, ND**. Prior to your first visit, we'd like to make you aware of our **Clinic Policies**:

1. **Please review the attached consent forms and our online privacy policy** & **terms and conditions**. You will need to have read these forms to be able to sign the attached consent form – which is mandatory prior to receiving treatment. You will sign this consent form at your first visit.

2. Your initial consultation will last up to 90 minutes, and includes an in-depth review of your health concerns and goals. This visit focuses on assessment, including (as needed, and as time allows) screening physical exam and review of available lab work. **If you have copies of lab tests done in the past 6-12 months, please BRING IT TO YOUR FIRST VISIT.** If not, we will fill out a form to request them from your MD. Additional or up-to-date diagnostic tests may be recommended, and introductory treatment guidelines are presented.

3. Your **second visit will last up to 60 minutes**, and includes review of short & long term goals of treatment and the presentation of a comprehensive and individualized treatment plan. **Subsequent visits** are typically **45- 60 minutes** in length, but brief/acute 15-30 minute visits are available.

4. After your initial consultation, please use our **online booking system** to make, change or cancel appointments. You will need to provide an email address that is regularly monitored. We can help you set up your account. While we offer a complimentary email reminder service to patients, **it is your responsibility to keep track of scheduled appointments**. If you need assistance at any time, call the clinic at **416.783.1800**.

5. **The office accepts cash, debit, VISA and Mastercard** as methods of payment, which is due at the end of each visit. We do NOT accept cheques. Most extended health benefits cover Naturopathic Medicine. Please check with your provider to determine the amount that is covered under your policy (or that of your spouse, parent or life partner). We do not deal directly with insurance companies. **You must pay all fees at the end of your visit**, and subsequently submit the invoice to your insurance company to be reimbursed. We will provide you with a detailed receipt.

6. **Please note that we require a MINIMUM of 48 hours advance notice to cancel or change a scheduled appointment. Otherwise, you will be charged 100% of the cost of the scheduled visit.** By signing the following consent form you agree to pay all fees incurred by you, including that of a missed visit.

7. Please note that the clinic has a **scent-free policy.** To respect those clients with allergies or sensitivities, **please avoid perfumes and scented cosmetics** when attending the clinic.

8. I carry a select number of professional products in my **on-site dispensary** for the convenience of my patients, and keep my prices competitive. However, you are welcome to purchase prescribed items elsewhere. I also have an online dispensary where you can purchase and direct ship products to your home.

9. Clinic Policies may change from time to time. **Please be sure to provide us with a valid email address so that we may keep you up to date via our NEWSLETTER.** We send out a seasonal Newsletter by email which may contain updates to policies and other clinic news. Please review them. By signing your consent to provide information and receive care, you are also permitting me to add you to my e-newsletter list to receive these updates.

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10. There is lots of excellent information on my website. Feel free to browse through it at your own pace. I especially encourage you to have a look at the "Patient Info" and "About" pages before your first visit.

Thank you for taking the time to review our Clinic Policies.

I look forward to meeting with you soon. Kindly give me a call at (416) 783-1800 or have a look at my website **drjenniferbaer.com** if you have any additional questions.

Wishing you good health and abundant joy,

Dr. Jennifer Baer, ND
Digestive Health
Doctor of Naturopathic Medicine
Registered Holistic Nutritionist

DIGESTION. Your *health* depends on it.

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INFORMED CONSENT

I would like to take this opportunity to welcome you to **Body of Knowledge Healing Arts**. I aim to use the principles and practices of Naturopathic Medicine to assist the body's natural ability to heal, to prevent disease & promote wellness, and to improve quality of life and health through natural means.

I will begin with a thorough case history. Assessment of your physical, mental, emotional and spiritual well-being is required to facilitate this work. Screening physical exam, and specific blood, urinary, or other laboratory reports may be used as part of the assessment.

Therapies used by a Naturopathic Doctor may include: Clinical Nutrition, Botanical Medicine, Homeopathy, Traditional Asian Medicine & Acupuncture, Lifestyle Counselling & Stress Management, Hydrotherapy, and Physical Medicine including massage and soft tissue manipulation.

Statement of Acknowledgement

I, (print your name) _____ , acknowledge that as a new patient (or parent/guardian of a new patient) of this clinic, I have read the information included herein, and understand that the form of medical care is based on Naturopathic Medicine and other supportive principles and practices. I also recognize that although uncommon, even the gentlest therapies have potential complications in certain physiological conditions such as (but not limited to): pregnancy, lactation, very young children, very elderly patients, or those on multiple medications.

I therefore confirm that I have informed my (or my child's) practitioner fully (and will continue to inform her throughout the course of our therapeutic relationship) of my (or my child's) medical history, family history, medications and/or supplements I (or my child's) am/is taking (prescription and over-the-counter), or was previously taking. If female, I have advised my practitioner of any chance that I am pregnant, and will continue to do so.

Despite the low incidence, there are some slight risks to Naturopathic treatments. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or acupuncture
- muscle strains and sprains, disc injuries from spinal manipulations

I understand that a record will be kept of the health services provided to me (or my child). This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at this medical record at any time and may request a copy of it by paying the appropriate fee.

I understand that my (or my child's) practitioner will answer any questions I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and/or complications.

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With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments outlined above except the following (list any therapies you do not wish to participate in):

I understand that charges are to be paid at the time of the visit. As the patient (or guardian), I am responsible for the total charges incurred at each visit, and have been informed of the fee schedule and accepted methods of payment. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 100% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a MINIMUM of 48 hours advance notice.

I understand that the clinic may change its policies and fees from time to time, and that they will post these changes on their website and send me an update of these changes electronically. I understand that it is my responsibility to provide an up-to-date email address to the clinic, and to inform them should my email address or contact information change. By signing this consent form I agree to the policies outlined herein, and any changes to clinic policies throughout the term of my relationship as a patient (or guardian of a patient) of this clinic.

I have read and understand all of the above-stated policies and information. I intend this consent form to cover the entire course of treatment I (or my child) receive(s) at **Body of Knowledge Healing Arts, under the care of Jennifer Baer, RHN, ND**. I understand that I am free to withdraw my consent with written notice and to discontinue treatment at any time. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.

_____

(printed name – please specify if you are a guardian and include your name & the child's name)

_____ _____

(signature) (date)

_____

(witness' printed name)

_____ _____

(witness' signature) (date)

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PATIENT INFORMATION AND PRIVACY FORM: How to access our privacy policy and patient consent for the collection, use & distribution of personal information.

Privacy of your personal information is an important part of our office's pledge to provide you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

Our Privacy Information Officer is Jennifer Baer, ND and she will attempt to answer any questions or concerns that you might have. Jennifer can be reached by email at: **health@drjenniferbaer.com** . If you have a concern and/or wish to make a complaint to us about our privacy policies, you must make your request in writing. Our Privacy Officer will promptly acknowledge receipt of your complaint in writing, and will ensure it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision.

If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information below.

Privacy Commissioner of Canada
112 Kent St.
Ottawa, ON K1A 1H3

Phone: 613-995-8210
Toll free: 1-800-282-1376
Fax: 613-947-6850

Our privacy policies and procedures comply with the federal legislation called the *Personal Information and Electronic Documents Act (PIPEDA*). This very complex law does provide for some exceptions to the privacy principles that are too detailed to outline here.

Our **Privacy Code** sets out this clinic's commitment to protecting your private health and personal information. It is available on our website.

Please be assured that we are committed to ensuring that you receive the best quality care. As such, any staff member who comes into contact with your personal information is aware of the sensitive nature of the information that you have disclosed to us, and has signed a confidentiality agreement to ensure that our Privacy Policy is upheld.

We ask that you review our Privacy Code, for details on what our office 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, standards of our regulatory body, and the law.
Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of the College of Naturopaths of Ontario, fulfilling its mandate under the RHPA, and for the defense of a legal issue.

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Our office will not, under any circumstances, directly supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent to use or disclose your personal information by written notification, and we will explain the ramifications of that decision, and the process. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent: (note: to sign this consent you must first access and read our Privacy Code available at: http://bokhealingarts.com under Patient Centre)

Statement of Consent to Collect Information:
I have accessed and read **Body of Knowledge Healing Arts'** Privacy Code, and am fully aware of the privacy policies of **Body of Knowledge Healing Arts,** how your office will use, collect, and disclose my personal information, and the steps your office is taking to protect my information. I agree that **Body of Knowledge Healing Arts** can collect, use, and disclose personal information about myself, as set out above and in the office's Privacy Code. I agree that Body of Knowledge Healing Arts can add me to their e-newsletter for updates on clinic news and policies.

_____

(printed name – please specify if you are a guardian and include your name & the child's name)

_____ _____

(signature) (date)

_____

(witness' printed name)

_____ _____

(witness' signature) (date)