PHYSIOTHERAPY
ADVANCED REHAB
Orthopaedic and Sports Injury Clinic
1250 Eglinton Ave. West, Unit A15 Mississauga, ON L5V 1N3
Tel: 905-997-7200 Fax 905-997-5000

Naturopathic Consent Form

Dear Patient:

Naturopathic medicine involves using natural therapies to treat and prevent disease by getting to the root cause. It encourages the body's own innate healing powers to take over. Dr. Dubier, ND will complete a thorough intake of medical history and perform any relevant physical examinations. Therapeutic procedures used in naturopathic medicine may include lifestyle/diet counselling, botanical medicine, clinical nutrition, traditional Chinese medicine, and homeopathy. You will receive information about any diagnoses, and/or treatment, alternative therapies, costs, expected benefits, risks, side effects and consequences of not treating. Please ensure to provide your ND with accurate health information including if you are pregnant, planning on becoming pregnant soon or breastfeeding.

As with all forms of medical treatment, there are benefits and risks involved with the use of natural therapies. Your practitioner will completely evaluate to ensure that risk of side effects is minimal. Although uncommon, potential side effects involved in treatment via naturopathic medicine include but are not limited to the following:

-Aggravation of pre-existing symptoms
-Allergic reactions to supplements or herbs
-Pain or bruising from acupuncture
-Fainting or puncturing of an organ with acupuncture needles

Physiotherapy Advanced Rehab (Health Information Custodian for your records) is responsible for protection, collection, use and disclosure of your personal information according to privacy rules set by Personal Health Information Protection Act (PHIPA) and by Personal Information Protection and Electronic Documents Act PIPEDA).

☐ I hereby consent to the rendering of naturopathic evaluation and treatment as deemed appropriate by Dr. Dubier. I have the right to decline treatment at any time.

☐ I authorize the release of all necessary information to my primary care provider and/or physician

☐ I authorize the release of all necessary information to ____ in regards to my care and/or status. (Ex: family, legal representative, employer, guardian, other)

☐ **I understand** that the service fees are *not covered under OHIP* & may not be covered or exceed my insurance plan or claim benefits and I am financially responsible for the entire cost of any unpaid claims.

The ND may correspond with you via email to provide general health information or answer questions. Please initial here if you consent to email contact: _______

Email address: ____

______________________________ ___________________________________ _______________

Patient/Guardian (Please Print) Signature Date