Dr. Allan Price BSc ND
Dr. Tara O'Brien HBSc ND
purewellnessgroup.ca

purewellness group

1596 Regent St, Sudbury, ON, P3E3Z6
p:705.586.7873 f:705.586.7874
reception@purewg.ca

Osteopathy Intake Form

To help us serve your health needs, please take 10-15 minutes to complete the following questionnaire as accurately as possible. All of your answers will be held *absolutely confidential.* If you have any questions, please ask. Thank you!

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code _____

Home Tel: _____ Work Tel: _____ E-mail _____

Occupation: _____

How did you hear about us? _____

Family Physician: _____Phone: _____

Other Health Care Providers: _____Phone: _____

What is your reason for seeking osteopathic treatment?

_____

_____

How did you hear about our clinic? ○ Aviita ○ Chamber of Commerce ○ Tradeshow ○ Drive By/Walk In ○ Medical Doctor ○ Internet ○ Facebook ○ Google ○ Midwife ○ Website ○ Pure; A Wellness Magazine ○ Yellow Pages ○ Another patient or professional: _____

How would you rate your general Health Status: □ Poor □ Fair □ Good □ Excellent

Medical History

Please list current medications and/or supplements

Type	Dose	Taken for

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Surgeries / Injuries:

_____**Date:** _____

_____**Date:** _____

Please list all allergies / sensitivities:

_____

_____

Review of Systems

Please indicate ☑ any conditions that you are currently experiencing of have experienced in the past:

Cardiovascular
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Varicose Veins
- ☐ Pacemaker or device
- ☐ Heart Disease
- ☐ Stroke

Respiratory
- ☐ Chronic cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Muscular Discomfort
- ☐ Neck
- ☐ Low Back
- ☐ Midback
- ☐ Upper Back
- ☐ Shoulders
- ☐ Arms/Legs
- ☐ Knees
- ☐ Other:_____

Other Conditions
- ☐ Loss of sensation
- ☐ Diabetes
- ☐ Eczema/Psoriasis
- ☐ Acne
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis
- ☐ Headaches
- ☐ Eye/Vision Problems
- ☐ Ear/Hearing Problems
- ☐ Bleeding disorder
- ☐ Osteoporosis / Osteopenia
- ☐ Mental Illness
- ☐ Digestive condition
- ☐ Joint replacement / pins wires
- ☐ Infectious / Contagious diseases:
  _____
  _____

Gynaecological conditions
- ☐ _____
  _____

Pregnancy
- ☐ Due Date: _____

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Informed Consent of Osteopathic Treatment

Statement of Acknowledgement

I, (print your name) _____, acknowledge that as a new patient of the clinic, have read the information included herein, and understand that the form of medical care is based on Osteopathic principles and practices. I understand that my practitioner will answer any questions I have to the best of his/her ability. I understand that the results are not guaranteed. I also recognize that even the gentlest therapies have potential complications in certain patients.

I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and/or supplements I am currently taking (prescription and over the counter), or was previously taking. I have also advised my practitioner of the possibility that I may be pregnant and will continue to do so.

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

- pain, fainting, bruising or injury
- drowsiness

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 without my consent, unless required by law. 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.

Pure Wellness Group Fee Schedule for Osteopathic visits:

Adults
Initial visit: $ 150.00
60 minute visit: $ 145.00
45 minute visit: $ 115.00
30 minute visit: $ 85.00

Pediatric (1-14 yoa)
Initial visit: $90
30 minute visit: $60

Infants (< 1yoa)
FREE

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I understand that charges are to be paid **at the time of the visit**. As the patient, 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 50% of the cost of each scheduled visit should I miss, cancel or wish to change a previously scheduled appointment without providing a **MINIMUM** of 24 hours advance notice.

I understand that ***Pure Wellness Group*** **does not provide refunds** for services, treatments or supplements. While our policy is firm, we will do everything we can to work with you to make your experience with us as positive as possible.

Please be advised that the above fee schedule is subject to change. ***Pure Wellness Group*** will advise all patients of price changes if and when they occur.

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 receive at ***Pure Wellness Group***. 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. By signing below, I acknowledge that I understand the risks involved and the conditions under which my treatments will be provided. I will not hold ***Pure Wellness Group***, its owners, or its employees responsible.

_____ _____
(Patient's signature) (Date)

_____ _____
(Witness's signature) (Date)

☐ I would like sign up for ***Pure Wellness Group*** newsletters and updates

E-mail address _____

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PATIENT INFORMATION AND PRIVACY FORM:

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 Tara O'Brien. Tara will attempt to answer any questions or concerns that you might have. Tara can be reached at the address and phone number above, or by email at: **reception@purewg.ca.** If you do 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 response in writing indicating any decisions/actions, and the reason for such.

If you are dissatisfied with the actions or decisions, 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: 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 the offices' commitment to protecting your private health and personal information. It is available by request from any of our office staff, or on our website.

Please be assured that every staff member in our office is committed to ensuring that you receive the best quality care. As such, all staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

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 office will not under any circumstance 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/or disclosure of your personal information, we will seek your approval in advance.

Statement of Consent to Collect Information:

I have read and understood the above information, and am fully aware of the privacy policies of ***Pure Wellness Group*** 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 ***Pure Wellness Group*** can collect, use, and disclose personal information about myself, as set out above and according to the PIPEDA guidelines.

_____ _____
(Patient's signature) (Date)

_____ _____
(Witness's signature) (Date)