ROWAN

HEALTH AND WELLNESS CLINIC

Consent Form

1 Hunter Street East, Suite G100
Hamilton, ON L8N 3W1

Fax. 905.575.5863
info@rowanhealth.ca
www.rowanhealthandwellness.com

The Keys To My Success

To be successful with my program, I will commit to the following:

- ☐ I will comply and follow through with Rowan Health and Wellness recommendations.
- ☐ I will modify my diet based on Rowan Health and Wellness recommendations and my functional lab test findings.
- ☐ I will take my recommended nutritional supplements.
- ☐ I understand that I may be required to keep a record of my food intake.
- ☐ I understand that my lifestyle may be a contributing to my condition and I will make modifications within reason (e.g. work demands, sleep habits, relationships).
- ☐ I will do my best to reduce stress.
- ☐ I may be required to change my home and personal care products.
- ☐ I will engage in the exercise regimen prescribed by Rowan Health and Wellness.
- ☐ I understand that I may need to repeat my functional lab tests.
- ☐ I will utilize all resources made available by Rowan Health and Wellness to maximize my success.
- ☐ I will notify Rowan Health and Wellness immediately if I have any concerns regarding my program.
- ☐ I realize that my health concern(s) may take longer than 6 months to improve.
- ☐ I realize that there may be times that I need to see a specialist in addition to Rowan Health and Wellness.

Patient Name: _____Date: _____

Patient Signature: _____

Witness: _____

Important Patient Information

Appointments

- There is a 48-hour cancellation policy (please see cancellation policy in Practice Policies for Patients).
- It is your responsibility to keep the scheduled appointment or reschedule.

Billing/Insurance

- Payment for the office visit, or phone consultation or lab tests is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day of the visit or phone call.
- We do not accept insurance and we cannot assist you with claim resolution. We will provide you with a billing summary which you can submit to your insurance carrier.
- Our services are not tax deductible. Functional medicine is currently not recognized as a medical expense.

Informed consent regarding email or the internet use of protected personal information.

Rowan Health and Wellness provides patients the opportunity to communicate with their health care providers and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

    a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
    b. Specific e-mail risks are the following: e-mail containing information pertaining to functional lab tests and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Rowan Health and Wellness that all e-mail messages sent or received which concern the functional lab tests of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Rowan Health and Wellness will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.

3. Patients must consent to the use of e-mail for confidential information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

    a. Rowan Health and Wellness may forward e-mail messages within the practice as necessary. Rowan Health and Wellness will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
    b. Rowan Health and Wellness will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
    c. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
    d. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
    e. Rowan Health and Wellness cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Rowan Health and Wellness is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
    f. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform Rowan Health and Wellness of any types of information you do not want to be sent by e-mail.

g. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from Rowan Health and Wellness to protect confidentiality. Rowan Health and Wellness is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Rowan Health and Wellness.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail.

I agree to assume all risks associated with the use of e-mail.

Privacy Policy

Under the Personal Health Information Protection Act, 2004 (PHIPA), you have the right to consent, or to withhold your consent, to the collection, use and disclosure of your personal health information, except in specific circumstances where the law authorizes Rowan Health and Wellness to collect, use or disclose your information without consent.

Rowan Health and Wellness collects your personal health information directly from you, from a person acting on your behalf, and from others such as healthcare providers. Rowan Health and Wellness will not collect more personal health information than is reasonably necessary to meet its purposes.

Rowan Health and Wellness uses personal health information to:

- To assess your health needs and provide safe and efficient care
- Plan a strategy to address your concerns
- To enable us to contact and maintain communication with you to distribute health care information and to book and confirm appointments
- To communicate with other treating health care providers, including other dentists, physicians, pharmacists and lab technician (with your consent and if required)

Our office will ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols
- We do not share your information with any government or insurance agency

Communication Guidelines

Direct email access is a very effective form of communication and allows us to better serve our patients. In order to provide the highest level of care, please read this brief policy document to enhance your interaction with your clinician and ensure prompt delivery and response time.

1. It is important to remember that emails do not replace appointments. Email questions should be regarding your case (updates, protocol questions, troubleshooting symptoms). Some questions may not be answered via email and will require that you wait until your appointment or schedule a phone consultation.

Acceptable Email:

> Hi,
> I just wanted to provide a quick update. I feel much better since starting my program and have better energy, better sleep, and better digestion. I had a quick question regarding the probiotic. Is it okay to take this with a meal?
> Thanks!

Needs An Appointment:

> Hi Dr.
>
> I had a few questions. I wanted to know about how to bring my energy up and make my digestion better. I also wanted to know your thoughts on how to lower blood pressure and blood sugars. I have not completed any of the testing yet but will be doing those soon. Should I be taking Vitamin A, Vitamin C, Vitamin D, or can I get this all from food? How do I know I am eating enough? What are your thoughts on detoxification and methylation. I know these are big topics and I wanted to know your thoughts.
>
> My husbands health is also not good and I wanted to know if you had any suggestions for him. Does he require the same vitamins as me. What should he be eating?We will be going on vacation in the upcoming few months, is it something I should be worried about. What should my kids be eating. They are both in school. I saw this interesting documentary last night that said I should be juicing. Is this something I should start doing immediately.
>
> Can you let me know if there are any supplements to help with sleep. I have trouble falling asleep. I wake up tired in the morning and can't do anything.
>
> Thanks

2. The subject of your email should be very clear and specific. If the topic of the conversation changes, please change the subject of the email for easier search and follow up.

3. Please check your spam to ensure proper email delivery.

4. Please include all clinicians that are working on your case. This will ensure quick handling of your email.

5. Please do not reply to your appointment emails. These are sent automatically from our scheduling software. If you need to change an appointment please email your provider directly.

6. You may schedule a new appointment online here: www.livingproofappt.com

7. Emails are answered as quickly as possible. Please give us 1-2 business days to respond. If your email is urgent please type URGENT in the subject and we will reply ASAP.

8. If you have an emergency, please call 911 or emergency services.

Thank you for following these policies. We look forward to your questions.

Functional Medicine - Informed Consent

Care Program

Functional Medicine involves the recommendation of lifestyle, dietary and supplement changes and additions based on my history and functional medicine test findings. Functional medicine uses the most recent research to assess the body as a whole emphasizing the relationship between your body and your internal and external environment.

The relationship between the client and functional medicine provider includes mentorship and guidance towards achieving a healthy balance within the body. I understand that no diagnoses are made and no treatment for a pre-existing diagnosis will be rendered. Functional medicine addresses the underlying pathophysiology that may be contributing to these prior diagnoses.

Testing

Functional lab testing involves the evaluation of nutritional, biochemical and physiological imbalances. It is important to remember that these lab tests are not intended to diagnose a disease. The testing will help make the appropriate recommendations. This testing is not intended to replace the testing provided by your medical physician.

Recommendations

All recommendations are meant to be in the patient's best interest and I acknowledge that the functional medicine practitioner may not be able to anticipate all risks and complications. I will keep my medical doctor fully informed about any changes in supplements, diet, and any other pertinent information. I understand that I have to consult with my medical doctor if I want to make any changes to any of my medications.

Consent

I acknowledge that I have discussed, or have had the opportunity to discuss, with my functional medicine provider the nature and purpose of the consultations and the contents of this Consent Form. I agree to accept the care program on my own free will and I have read the consent form in its entirety. I provide consent for functional medicine care for the duration of this program and any future consultations required.

Primary Care Physician

Please note that we are not your primary care physicians. We recommend that you have a primary care physician.

Patient Name: _____ Date: _____

Patient Signature: _____

Witness: _____

SUBMIT