Manuel To Health
Naturopathic Centre

OFFICE POLICIES

Manuel To Health Naturopathic Centre (M2HNC) has established the following policies in order to ensure the most efficient service to our clients:

- We require a minimum **24 hour notice** for all appointment cancellations or changes. Please leave messages on our answering machine during off-hours.
- For all missed appointments without notification, there may be a charge for the appointment.
- When you arrive late for your appointment, only the balance of the time that was booked for you can be used.
- M2HNC has a **SCENT-FREE** policy. Scents include smells or odours from cosmetics (i.e. perfume, shampoo, make-up etc.) or from other products like air fresheners, cleaning products, etc. These scents may affect other clients' health, especially those with environmental sensitivities.
- Clients **must turn off** all electronic devices during their visits (i.e. cell phone, pagers etc.).
- Full payment is made at the time of your visit, unless prior arrangement has been made with Manuel To Health Naturopathic Centre. Acceptable tenders for transactions are Cash, Cheque, Debit, Visa, or Mastercard.
- The fee for each **NSF** Cheque is $45.
- M2HNC must authorize all product returns.
- Returns must be made with the original receipt **within 14 days** for **credit only** on account. No cash, cheque or credit card refunds will be issued.
- Opened, damaged, or expired products **will not** be accepted for credit.

STATEMENT OF ACKNOWLEDGEMENT AND INFORMED CONSENT

Manuel To Health Naturopathic Centre (M2HNC) is an office with Naturopathic Doctors providing naturopathic health care. Naturopathic Medicine uses non-invasive techniques for the assessment of each client's health and provides natural therapies for treatment.

M2HNC uses Functional Biometry, such as Meridian Stress Assessment System (MSAS) testing and metabolic urine testing, with structural, nutritional, and lifestyle techniques in the assessment of each client. Some of these techniques are considered non-diagnostic, and hence, does not diagnose, treat, prescribe or cure any disease. The purpose of these techniques are to assist in the overall assessment of the client in order to provide optimal quality care to all clients.

There are some health risks associated with naturopathic medicine treatment.
These include, but are not limited to:

- Pain, bruising or injury from acupuncture or injections.
- Homeopathic remedies may occasionally result in aggravation of pre-existing symptoms. The duration is usually short when this occurs.
- Some clients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you have.
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

Each client must sign this document before any treatment is rendered. Your signature acknowledges and consents to the following:

1. You understand that the ultimate responsibility of your health is your own.
2. The clinic does not guarantee treatment results.
3. The Naturopathic Scope of Practice will be used.
4. You understand that the treatments provided and/or referred to other health practitioners is based upon the assessment of conditions revealed via your personal history and interview, physical assessment, laboratory testing, and methods used to evaluate the energetic status of the body.
5. You understand that the practice of Functional Biometry, such as Meridian Stress Assessment System Testing, is at this time, considered non-standard and experimental.
6. Failure to follow sound nutritional, exercise and lifestyle programs can undermine the expected results.
7. You are free to withdraw consent and to discontinue treatment at any time.
8. You accept full responsibility for any fees incurred during care and treatment at the time of visit unless prior arrangement has been made with M2HNC.
9. A minimum of 24 hours notice is required for appointment cancellations and changes. Otherwise, you may be billed for missed appointments.
10. Naturopathic Medicine and Conventional Medical Treatment are not mutually exclusive and you have been given the option to continue seeking conventional medical treatment.
11. It is your responsibility to determine whether your health insurance covers Naturopathic Medicine services, treatments, and prescribed natural health products. M2HNC will charge a fee by time for extra paperwork required for uncertain claims for reimbursement.

I, _____ (Print name), have read, understood, acknowledge, and consent to the above statements.
Signed this _____DAY of _____, 20____, at _____ (City/Town), _____(Province), _____(Country)

Signature:_____(Client, Parent or Guardian)

Manuel To Health
Naturopathic Centre

Naturopathic Intake Form - Adult

Please complete the following form as accurately and fully as possible. This information is essential for your Naturopathic Doctor to assess your total health picture as it relates to your current condition.

PERSONAL/GENERAL INFORMATION

First Name: _____ Middle Name:_____ Last Name:_____
Address: _____ City/Town: _____ Province:_____
Postal Code: _____ Home Phone: _____ Cell Phone: _____
Email: _____
Mailing Address (If different from above): _____
_____
Emergency Contact: Name:_____ Relationship:_____
Phone number:_____ Cell number:_____

Date of Birth: _____day _____month _____year Present Age:_____
Occupation: _____

Marital Status: Single ____ Married ____ Divorced _____ Separated ____ Widowed ____

How did you learn about our clinic? Relative ___ Friend ____ Professional ____
Name: _____

List of other Health Practitioners you are currently seeing or have seen in the past: (i.e Types: Family doctor, Specialist doctor, Chiropractor, Acupuncturist, Massage Therapist, Physiotherapist, Herbalist, etc.)
Name _____ Type _____
Name _____ Type _____
Name _____ Type _____
Name _____ Type _____
Name _____ Type _____

HEALTH HISTORY

Chief Complaint (Main Concern): _____
Reason/Goal of visit: _____

Please list other health concerns, in order of importance/severity, including start dates:
1. _____ Start date: _____
2. _____ Start date: _____
3. _____ Start date: _____
4. _____ Start date: _____
5. _____ Start date: _____
6: _____ Start date: _____

When did the main condition begin?_____

Is there pain or discomfort? Y / N If yes, please describe the pain:_____)_____

Have you had this condition before? Y / N If yes, when?_____

Is it related to an accident? Y / N Please explain:_____

Any other symptoms associated with the condition? If yes, please list (in order of severity):
1. _____ 3. _____
2. _____ 4. _____

Symptoms worse at what time of day? (circle) None / Awake / Afternoon / Evening / Night

Symptoms relieved by medication? (circle) Yes / No
If yes, list medication(s) _____

MEDICAL HISTORY

Please list any serious conditions, illnesses, injuries, etc. you currently have or had and their dates:

Date	Condition/Illness/Injury
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any surgeries (i.e. removal of tonsils, appendix, hysterectomy, c-section etc.) and their dates:

Date	Surgery
_____	_____
_____	_____
_____	_____

Please list any hospitalizations and reason for stay:

Date	Hospitalization
_____	_____
_____	_____
_____	_____

Any birth defects? o Yes o No If yes, explain:_____
Any birth injuries? o Yes o No If yes, explain:_____

List all PAST medications (includes birth control), dose, any side effects, and dates discontinued:

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____

List all CURRENT medications (includes birth control), dose, and start date of medication:

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____
6) _____ _____

List all CURRENT supplements/remedies (i.e. herbs, vitamins/minerals, homeopathics etc.) with dosage (include brand name if possible):

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____
6) _____ _____

Do you currently have or had in the past the following communicable disease?

Measles	o Yes	o No	Scarlet fever	o Yes	o No
Mumps	o Yes	o No	Tuberculosis	o Yes	o No
German measles	o Yes	o No	Infectious mononucleosis	o Yes	o No
Rheumatic fever	o Yes	o No	Polio	o Yes	o No
Chicken pox	o Yes	o No	Meningitis	o Yes	o No
Whooping cough	o Yes	o No	Gonorrhea	o Yes	o No
Influenza	o Yes	o No	Syphilis	o Yes	o No
Diphtheria	o Yes	o No	Other: _____		

Have you ever had any reactions to vaccinations? o Yes o No
If yes, which ones and explain:_____

ALLERGIES AND SENSITIVITIES

List any allergies you have (i.e. medicines, environmental, food etc.) and your reaction to them?

_____
_____
_____
_____

Do you require emergency treatment for your allergy o Yes o No
List current allergy treatment, if any:_____
_____
_____

List any sensitivities you have (i.e. food, body care products, insects, scents, plants etc.) and your reaction to them:

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____

FAMILY HISTORY

Please indicate (with a check) all family medical history, and list their relationship to you (mother, father, brother, sister, aunts/uncles, grandparents, etc.) for:

__Diabetes_____ __Allergies_____
__Cancer_____ __Asthma_____
__Heart Problem_____ __Thyroid Problem_____
__High Blood Pressure_____ __Kidney Disease_____
__High Cholesterol_____ __Mental Disorder_____
__Genetic Defect_____ __Drug/Alcoholism_____
__Other:_____

REVIEW OF SYSTEMS

Please check any of the following symptoms which you experience:

SKIN, HAIR, NAILS:

- o Acne
- o Itching
- o Rash
- o Redness
- o Dry skin
- o Oily skin
- o Bruise easily
- o Boils
- o Hives
- o Peeling
- o Scaly lesions
- o Weepy lesion
- o Edema (swelling)
- o Dry hair
- o Falling/thinning hair
- o Foot odour
- o Bunion
- o Nail fungus

List main areas involved:_____

HEADACHE: Do you have any headaches? o Yes o No

If yes, please describe the pain, location and intensity:

- o Dull
- o Achy
- o Heavy
- o Sharp
- o Burning
- o Throbbing
- o Pressure
- o Band-like
- o Dizziness
- o Constricting
- o Pulsating
- o Constant
- o Comes and goes
- o On the right side
- o On the left side
- o Top of the head
- o Behind the eyes
- o Between eyes
- o Back of head
- o Forehead
- o Temple
- o Upper teeth
- o Mild
- o Excruciating

Anything that makes the headache feel better? _____

Anything that makes the headache worse? _____

Do you feel any associated pain with the headache? o Yes o No

If yes, where? _____

EYES:

- o Itchy
- o Red
- o Dry
- o Swollen
- o Bloodshot
- o Dark circles
- o Burning
- o Watering
- o Styes
- o Cataracts
- o Glaucoma
- o Pain
- o "Floaters"
- o Blurry vision
- o Wear glasses and/ or contacts
- o Far-sighted
- o Other_____
- o Near-sighted
- o Twitchy lid
- o Crusty lid
- o Sensitive to light
- o Loss of sight

EARS:

- o Hearing loss
- o Itchy
- o Pressure
- o Dizziness
- o Excessive ear wax
- o Tubes in ears
- o Plugged ears
- o Other_____
- o Pain
- o Frequent infections
- o Ringing
- o Fluid inside
- o Wear hearing aid

NOSE/SINUS:

- o Itchy
- o Runny
- o Burns
- o Bleeds
- o Blocked
- o Yellow mucus
- o Blood-streaked mucus
- o Polyps
- o Deviated septum
- o Loss of smell
- o Sneezing
- o Post nasal drip
- o Sinus infection
- o Other_____

When do the symptoms occur?

- o Spring
- o Summer
- o Winter
- o Fall
- o Year round
- o Upon rising
- o When lying down
- o Night
- o After meals
- o Cold
- o Hot
- o Dry

MOUTH:

- o Chapped lips
- o Cankers
- o Cracked lips/corner
- o TMJ
- o Grind teeth
- o Gum problems
- o Dentures
- o Itchy mouth
- o Sore tongue
- o Swollen tongue
- o Bad breath
- o Altered taste
- o Bad taste
- o Teeth pain
- o Fillings, which type? _____

Do you have any root canals? o Yes o No If yes, which teeth? _____

Do you have amalgam fillings? o Yes o No If yes, how many? _____

THROAT:

- o Itchy throat
- o Throat clearing
- o Pain
- o Loss voice
- o Hoarse voice
- o Sore throat
- o Difficulty swallowing
- o Throat closes
- o Swollen neck glands
- o Other_____

HEART/CIRCULATION:

- o Palpitations/racing heart
- o Skipped beats
- o Murmur
- o Tingling
- o Chest pain
- o Bruise easily
- o High blood pressure
- o Angina
- o Enlargement
- o Blue lips
- o Ankle swelling
- o Bleeding tendency
- o Rheumatic fever
- o Pacemaker
- o Congenital defects
- o Heart disease
- o Numbness
- o Anemia
- o Blood type _____
- o Leg cramps
- o Cold hands/feet
- o Deep leg pain
- o Ulcers
- o Varicose veins
- o Other_____

RESPIRATORY:

- o Difficulty breathing
- o Cough – dry
- o Cough – mucus
- o Wheezing
- o Asthma
- o Bronchitis
- o Pneumonia
- o Emphysema
- o Fluid in lungs
- o Heavy chest
- o Tight chest
- o Croup
- o Short of breath
- o Spitting blood
- o Lesions on chest
- o Other_____

GASTROINTESTINAL:

o Bloating	o Nausea	o Vomit blood	o Gallbladder disease
o Heartburn	o Vomiting	o Belching	
o Good/poor appetite	o Cramping	o Stomach ache	o Diarrhea
	o Picky eater	o Anal itch	o Constipation
o Indigestion	o Ulcer	o Hemorrhoids	o Laxative use
o Flatulence	o Hernia	o Liver disease	o Pain _____

How often do you have a bowel movement? _____

Describe your stool:	o Tarry stool	o Bloody stool	o Undigested food
	o Mucus in stool	o Colour_____	

URINARY:

o Bedwetting	o Kidney stones	o Increased frequency	o Difficult urination
o Kidney disease	o Painful urination		o Discharge
o Bladder disease	o Burning	o Hesitancy	o Frequent infections
o Incontinence	o Urgency	o Blood in urine	

MALE REPRODUCTIVE: (Men Only)

o Prostate problem	o Hernia	o Low sex drive	o Impotency
o Sores/Lesions	o Discharge	o High sex drive	o Erection issue:___
o Lumps	o Infection	o Dribbling	o Other_____
o Pain_____	o Venereal diseases	o Split-stream	_____

FEMALE REPRODUCTIVE: (Female Only)

o Sore breasts	o Partial/Total hysterectomy	o Vaginal burning	o Vaginal itching
o Breast cysts or lumps	o Venereal disease	o Pain on intercourse	o High sex drive
			o Low sex drive
o Breast biopsy	o Vaginal dryness	o Had D & C	o Nipple pain
o Had mastectomy	o Use lubricants	o Had C-section	o Nipple discharge
o Breast implants	o Vaginal discharge	o Had miscarriage	o Other_____

Age of onset of menses? _____ Last menstrual cycle _____
Length of period _____ Last PAP test _____
Length of cycle _____ Bleeding between period? Y / N
Regular period? Y / N Clots? Y / N Clot size? _____
Heavy flow? Y / N
Symptoms before period _____
Symptoms during period _____
Sexually active? Y / N Type of contraception used _____
Age at menopause? _____ Menopausal symptoms _____
Are you currently pregnant? Y / N
How many pregnancies? _____ How many live births? _____
How many miscarriages? _____ How many stillbirths? _____
How many premature births? _____ Any adopted children? Y / N

MUSCULOSKELETAL:
Do you have muscle pain? o Yes o No If yes, where? _____

Rate severity (circle): 1(not severe) 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10(severe)

Do you have joint pain? o Yes o No If yes, where? _____

Rate severity (circle): 1(not severe) 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10(severe)

Have you ever had broken bones? o Yes o No If yes, where? _____
_____

Please check symptoms which apply:

o Limited movement	o Muscle weakness	o Muscle spasm
o Morning stiffness	o Tingling hand/feet	o Numbness
o Leg cramps	o Gait changes	o Dropping objects

NEUROLOGICAL:

o Seizures or convulsions	o Weak limbs	o Foot drop	o Loss of sensation
o Tics	o Numbness	o Spinal pain	o Loss of balance
o Fainting	o Blurred vision	o Lack of coordination	o Abnormal EEG
o Tremor	o Double vision	o Paralysis	o Neurological disorder _____
o Memory problem	o Speech impairment	o Tingling	_____

ENDOCRINE:

o Overactive thyroid	o Lack of appetite	o Increase in appetite	o Excessive sweating
o Underactive thyroid	o Excessive thirst	o Weight gain	o Hot/Cold intolerances
o Enlarged thyroid	o Hypoglycemia	o Weight loss	
	o Diabetes		

PSYCHOLOGICAL:

o Mood swings	o Anger/Aggressive	o Grief	o Clumsy
o Depression	o Joy	o Fear	o Hyperactive
o Anxiety	o Sad	o Feel groggy	o Short attention span
o Forgetful	o Worry	o Restless legs	
o Other _____			

LIFESTYLE HISTORY

Height:_____ Weight:_____ Maximum weight and when?_____

Has your weight been relatively stable? _____

Date of last physical examination:_____ Blood Pressure:_____/_____mmHg

Please describe a typical day's diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages (quantity per day): Regular Tea_____ Herbal Tea_____ Milk _____ Juice _____

Coffee_____ Decaf Coffee_____ Soft Drinks _____ Water_____ Other:_____

Are you currently following any type of diet? If so what type?_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?_____

How much alcohol do you consume weekly?_____ Types:_____

Do you smoke? Y / N If yes, how many cigarettes per day?_____

Recreational drug use? Y / N If yes, list types and how often?_____

Rate your stress level (circle): 0 (no stress) -----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (high)

What are your sources of stress?_____
_____

How do you cope with stress, and in what way do you reduce your stress?_____

Do you exercise regularly? Y / N
If yes, what type, for how long, and how often?_____
_____

Please list hobbies and other activities:_____
_____

SLEEP:

Number of hours of sleep _____

Difficulty falling asleep?	o Yes	o No		
Wake up rested?	o Yes	o No		
Wake in middle of the night	o Yes	o No	What time? _____	
Recall dreaming?	o Yes	o No		
Recurrent dreams?	o Yes	o No		
Take naps?	o Yes	o No	When? _____	How long? _____

ENERGY:

Rate your energy level (circle): 1(very low) -----2-----3-----4-----5-----6-----7-----8-----9-----10 (high)
Best energy time? _____ Lowest energy time? _____

ENVIRONMENT:

In your current or previous employment, do you handle any chemicals, solvents, heavy metals, animal material? (If yes, please describe):_____
_____
_____

What type of housing do you live in?	o House	o Mobile home	o Apartment/Condo
	o Work camp	o Farmhouse	o Other_____
How long have you lived there?	_____		
Is there any room(s) in your home which may cause you to experience symptoms?	o Yes	o No	If yes, where? _____ _____
Is there a mold?	o Yes	o No	
Is it quite dusty?	o Yes	o No	

Is there a lot of vegetation around?	○ Yes	○ No	
Do you live near a power generation station?	○ Yes	○ No	If yes, how near? _____
Do you live near transmission lines or a power transformer?	○ Yes	○ No	If yes, how near? _____
Do you live near a communication tower?	○ Yes	○ No	If yes, how near? _____
What type of water do you drink?	○ Tap water	○ Well water	○ Reverse Osmosis
	○ Brita filter	○ Bottled water - Brand:_____	
Do you use an air purifier?	○ Yes	○ No	

Is there anything else that you feel is important that has not been covered?

_____
_____
_____
_____

_____

Thank-you for completing the intake form

Signature:_____

Date:_____

Manuel To Health
Naturopathic Centre

PATIENT CONSENT FORM
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Liona Manuel B.Sc. ND acts as the Privacy Information Officer.

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 trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic 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 and standards of our regulatory body, the College of Naturopathic Doctors of Alberta (CNDA).

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our Clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

This Clinic will collect, use and disclose information about you for the following purposes:

- to assess your health concerns
- to provide health care
- to advise you of treatment options
- to establish and maintain contact with you
- to send you newsletters and other information mailings
- to remind you of upcoming appointments
- to communicate with other treating health-care providers

- to allow us to efficiently follow-up for treatment, care and billing
- to complete claims for insurance purposes
- to comply with legal and regulatory requirements of our regulatory body, the College of Naturopathic Doctors of Alberta, acting under the authority of Alberta's *Health Professions Act*.
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this clinic to comply with all regulatory requirements
- to comply generally with the law
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.
Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that *Manuel To Health Naturopathic Centre* can collect, use and disclose personal information about _____ as set out above in the information about the clinic's privacy policies.
(Patient's name)

_____ _____
Signature Print name

_____ _____
Date Signature of witness

Manuel To Health
Naturopathic Centre

PRIVACY POLICY

We, at Manuel To Health Naturopathic Centre are committed to collecting, using and disclosing personal information in a responsible manner, and only to the extent that is necessary for the services we provide. We will be open with our handling of your information, as you will see from this Privacy Policy.

Please note that in this document, patient and client are considered to be interchangeable terms.

What is personal information?

Personal information refers to any information that can identify an individual. Personal information that we collect **may** include:

- Name, address, telephone number, fax number, e-mail address, date of birth, social insurance number, occupation, name of employer, place of employment, insurance company, insurance coverage
- Education, gender, sexual orientation, ethnicity, health history, health records, family history, hours of work, income
- Activities or views e.g. religion, politics, opinions, community involvement

Information related to a person's business is not protected by privacy legislation.

Collecting Personal Information:

Primary Purposes: For our clients, the primary purpose for collecting personal information is to help us assess what your health concerns are, to advise you of your options, to provide the health care you desire and to establish and maintain contact with you.

Related purposes: For our clients, related purposes for collecting personal information include: invoicing and statements, accounting and tax records, follow up services, quality control, communication with other health care providers, insurance claims, education (e.g. newsletters/articles, seminar announcements), marketing and compliance with regulation by a licensing/regulatory body. You can choose not to be part of some of these related purposes; for example, declining seminar announcements or newsletters. Please be aware that it may not be possible to decline some of the related purposes, such as information required by a regulatory body.

For members of the general public (non-clients), our primary purpose for collecting personal information is to allow the practitioners or staff to follow up on inquiries, ensure your request was properly handled (quality control), and provide information updates if you have expressed interest in receiving such notices.

For contract staff, our primary purpose for collecting personal information includes: communications, client communication, accounting and tax records, quality control, and education.

Protecting Personal Information:

We understand the importance of protecting personal information. For that reason, we have taken steps to safeguard your personal information from unauthorized access, disclosure, use or tampering.

Safeguards are in place to protect your personal information against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.

Your personal information is protected, whether it is recorded on paper or electronically.

Practitioners and staff are trained to collect, use and disclose personal information only as necessary to fulfill their duties and in accordance with our Privacy Policy.

Retention and Destruction of Personal Information:

Client files (containing personal information) will be maintained for a minimum of seven years.

Care is exercised in the destruction of personal information to prevent unauthorized access to the information even during disposal and destruction.

Accuracy of Personal Information:

This clinic endeavours to ensure that your personal information is as accurate, complete, and as up-to-date as necessary for the purposes that it is to be used.

Information shall be sufficiently accurate, complete and up-to-date to minimize the possibility that inappropriate information is used to make a decision about you as our patient.

With only a few exceptions, you have the right to see what personal information we hold about you.

If you believe there is a mistake in the information, you have the right to ask for it to be corrected. This applies to factual information and not to any professional opinions we may have formed.

Consent:

This clinic will seek informed consent for the collection, use and/or disclosure of personal information, except where it might be inappropriate to obtain your consent, and subject to some exceptions set out in law.

Consent is required for the collection of personal information and subsequent use or disclosure of that information. In order for the principles of consent to be satisfied, our clinic has undertaken reasonable efforts to ensure that you are advised of the purposes for which information is being used, and that you understand those purposes. Once consent is obtained, we do not need to seek your consent again, unless the use, purpose or disclosure changes.

Consent for the collection, use and disclosure of personal information may be given in a number of ways, such as:

- signed medical history form;
- signed introductory questionnaire;
- taken verbally over the telephone and then charted;
- e-mail;
- written correspondence

You may withdraw consent upon reasonable notice.

Do You Have a Concern?

Our information Officer is Liona Manuel B.Sc. ND, who can be reached at 587-280-9888 or via email at liona.manuel@m2hnc.ca to address any questions or concerns you may have.

If you wish to make a formal complaint about our privacy practices, you may make it in writing to our Information Officer. She will acknowledge receipt of your complaint, ensure that it is investigated promptly, and that you are provided with a formal decision and reasons in writing.

Thank you for your interest in our Privacy Policy. If you have a concern about the professionalism or competence of our services, or the mental or physical capacity of any of our professional staff, we would ask you to discuss those concerns with us. However, if we cannot satisfy your concerns, you are entitled to file a complaint with any of the regulatory boards of the individual practitioner(s). For example, if you have a complaint concerning one of our naturopathic doctors, you can contact the College of Naturopathic Doctors of Alberta (call 403-266-2446 or at www.cnda.net).