

Michelle Richea, BSc, ND Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

Welcome to Naturopathic Medicine. A holistic philosophy is the foundation underlying Naturopathic Medicine, and so it is from this whole-person perspective that I seek to gain a comprehensive understanding of all aspects that may be affecting your health. As your Naturopathic Doctor, it is important that I am aware of your current health status, your complete medical history, as well as what areas of your health you would like to see change in the future. Please complete this form as thoroughly as possible, as your responses will greatly assist in the development of a personalized treatment plan.

***Please bring all of the completed forms in this package with you to your first visit.**

Name: _____ Today's date: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: _____
Month Day Year

Occupation: _____

Live with: spouse partner children (how many? _____) roommate parents alone

CONTACT INFORMATION *Please inform us if your contact information changes*

Address: _____
City: _____ Province: _____ Postal Code: _____
Phone (H): _____ (Bus.): _____ (Cell): _____
E-mail: _____

If you would **not** like us to leave you a message at one/ any of the numbers provided above or would **not** like to receive communications by email please let your doctor know.

Emergency Contact

Name: _____ Relationship: _____
Phone (H): _____ (Bus.): _____ (Cell): _____

HEALTHCARE PROVIDERS:

Primary Health Care Physician: _____ Phone: _____
When was your last physical exam? _____

Are you currently under the care of a specialist? Yes No

Name: _____ Specialty: _____ Phone: _____
Name: _____ Specialty: _____ Phone: _____

CONTEXT OF CARE

What about Naturopathic Medicine interests you?

What expectations do you have for **THIS VISIT**?

What are your **LONG TERM** health goals?

What expectations do you have of me personally as your naturopathic doctor?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? *(Please rate from 1 to 10, 10 being 100 % committed).*

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe **SUPPORT** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **NOT** supportive of optimal health?

What potential obstacles do you foresee in addressing the lifestyle factors, which may undermine your health and would decrease compliance in adhering to the therapeutic protocols which I will be sharing with you?

Who do you know that will sincerely support you consistently with the potential lifestyle changes you will be making?

How would you describe your general state of health?

HEALTH CONCERNS

Please list your health concerns, in order of greatest importance to you.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

Are there any traumatic life events you've experienced (physical/ mental/ emotional) that you feel may be associated with your current health concerns? _____

VITAMINS AND SUPPLEMENTS

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include the brand)	Total daily dose	Reason for Use	Duration of Use

PRESCRIPTION MEDICATIONS

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

Please list any medications used in the past 12 months, but have now discontinued.

Medications In the Past 12 Months	Total daily dose	Reason for Use	Duration of Use

Are there any medications that you have used for more than 5 years of your life, which you have not already mentioned? _____

Number of times on antibiotics in the past 10 years: _____

Do you regularly use any of the following? Laxatives Sleeping pills Antacids Painkillers Diet pills

If so, please indicate type, frequency, and amount: _____

MEDICAL HISTORY

How would you describe your general health during childhood? Excellent Fair Poor Very Poor

Have you ever experienced chronic pain? Yes No, If Yes, please explain: _____

Which vaccinations have you had?

- HBV (hepatitis B) Hepatitis A Meningococcal Other: _____
 MMR (measles, mumps, rubella) Tetanus Booster Smallpox
 Hib (*Haemophilus influenza b*) Polio Typhus
 DPT (diphtheria, tetanus, pertussis) VZV (chicken pox) Influenza (flu shot)

Adverse Reactions

Please describe any adverse reactions, allergies, or sensitivities you have experienced with prescription or over-the-counter medications, recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals, homeopathics)

Name of drug, vaccine or natural medicine	Describe the reaction

Past Surgeries and Tests (*Please check all that apply*)

Surgeries	Year	Tests	Year
Abdominal/Gastrointestinal		Chest x-ray	
Appendectomy (Appendix removal)		Colon x-ray	
Brain		Abdominal x-ray	
Caesarean Section		Kidney x-ray	
Cancer		Echocardiogram	
Gallbladder		Electrocardiogram (ECG or EKG)	
Heart		Mammogram	
Hernia		Colonoscopy	
Mastectomy (breast)		Sigmoidoscopy	
Hysterectomy (ovaries/uterus/both)		TB test	
Sinuses		CT scan	
Tonsillectomy (tonsils removal)		MRI	
Tubes in ears		Ultrasound	
Vasectomy		Blood tests (specify if possible)	
		Other (specify)	

Please list any hospitalizations, reasons for hospitalization, and the year in which they occurred:

Please list any major injuries or traumas you have suffered and indicate the year in which they occurred:

FAMILY MEDICAL HISTORY

Relation	Significant Health Concerns/ Diagnoses	If deceased, list cause and age at death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

Do you have a family history that includes any of the following? (Please circle all that apply)

Cancer Cardiovascular Disease Alcoholism/ Addiction Depression Diabetes Thyroid Disorder

DIET

Please indicate the number of times per week that you eat or drink the following:

Food	# /wk	Food	# /wk	Food	# /wk
Fruits		Soy products (tofu, soy milk, etc.)		Fast food (MacDonald's, etc.)	
Vegetables		Soft drinks (regular)		Coffee	
Luncheon meat/smoked meat		Soft drinks (diet)		Regular (Caffeinated) Tea	
Breads and Baked goods		Salty snack foods (chips, etc.)		Herbal tea/ Green tea	
Cow's milk		Sweets (candies, cookies, etc.)		Wine/ Beer	
Cheese		Artificial sweeteners (Splenda, etc.)		Other alcoholic drinks	
Yoghurt		Meal replacement bars/drinks		Glasses of water/ day?	

Is there anything about your diet you would like to change? _____

On average how many meals do you eat per day? 1 2 3 4 5 >5

List any foods that you crave regularly: _____

List any foods you exclude from your diet: _____

Do you follow a specific diet regime? Vegetarian Vegan Other _____

Any known food allergies/ intolerances/ sensitivities? _____

LIFESTYLE

How many hours/ week on average do you work? _____ Do you enjoy your job? Y N

How many times per week do you exercise? Never < 1/wk 1-3/wk 3-5/wk >5/wk

What types of exercise do you do? _____

How long do you spend exercising each time? _____

Energy level (please circle): Low 1 2 3 4 5 6 7 8 9 10 High

Do you experience fatigue? Y / N Do you sleep well? Y / N Do you wake feeling well rested? Y / N

How many hours/ night do you typically sleep? _____

Do you have troubles falling asleep at night? Y / N If yes, Why? _____

Do you wake throughout the night? Y / N If Yes, Why? _____

How many times/ night? _____

Do you wake at the same time every night? Y / N

If Yes, what time(s)? _____

Do you snore? Y / N

Occurrence of sleepwalking: Y / N If Yes, Frequency: _____

How many hours of direct sunlight are you exposed to each week in the summer? _____ winter? _____

Do you use sunscreen regularly? Yes No, If No Why? _____

Do you smoke? Yes (# packs per day _____, # of years _____) Never smoked

Smoked in the past (# of years _____; # packs per day _____; Year that you quit _____)

Regularly exposed to second hand smoke? Y / N Use chewing tobacco

Do you use recreational/street drugs? Yes No In the past

If yes, which drugs, how often, and for how long? _____

Have you ever had a problem with an addiction? Y / N If Yes, Please specify (i.e. alcohol, food, drug):

When was your last vacation? _____

Travel history (please include destinations and dates of recent travel):

Mental/Emotional:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Prolonged sadness/ grief | <input type="checkbox"/> Easily angered | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Anxiety/ Nervousness | <input type="checkbox"/> Indecision | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Phobia | |

What are the major stresses in your life? (i.e. financial, job related, health, family, spiritual)

1. _____
2. _____
3. _____
4. _____

Has there been an event or illness from which you have never fully recovered from? _____

Indicate your current stress level on a scale of 1-10:

Low 1 2 3 4 5 6 7 8 9 10 High

How do you deal with stress? _____ Does this approach help sufficiently? _____

ENVIRONMENTAL EXPOSURES

Do you have pets in your home? Yes No Type of pets? _____

Are there any chemicals you're exposed to on a regular basis due to the nature of your job or hobbies?

REVIEW OF SYSTEMS

Height: _____ Weight: _____ Weight 1 year ago: _____ Desired weight: _____

If your present weight is different than your desired weight, how long has it been since you were at your desired weight? _____

Have you had an unexplained loss or gain of weight of 10 lbs or more in the past 6 months? Yes No

Please place a checkmark if you are currently experiencing or have recently experienced any of the following:

Endocrine:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> 20 lbs change in weight in the last year | <input type="checkbox"/> Sluggish after eating | <input type="checkbox"/> Hypoglycemia (low blood sugar) | <input type="checkbox"/> Generally feel hot |
| <input type="checkbox"/> Mental dullness | <input type="checkbox"/> Sluggish after coffee | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Generally feel cold |

Immune:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Chronic infections | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Frequent sore throats |
| <input type="checkbox"/> Frequent antibiotic use | <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Swollen glands/nodes | <input type="checkbox"/> Slow wound healing |

Neurological:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Concussion | <input type="checkbox"/> Loss of sensation | |

Skin, Hair and Nails:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Lumps/Abcesses | <input type="checkbox"/> Strong body odour | <input type="checkbox"/> Change in the size, shape, colour of a mole or freckle | <input type="checkbox"/> Brittle nails |
| <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Boils | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Thinning hair | | <input type="checkbox"/> Recent moles |

Head, Eyes, Ears, Nose and Throat:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Earaches | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Cavities |
| <input type="checkbox"/> Colour blindness | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Throat hoarseness |
| <input type="checkbox"/> Near sighted | <input type="checkbox"/> Poor sense of smell | <input type="checkbox"/> Itchy ear canal | |
| <input type="checkbox"/> Far sighted | <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Excessive ear wax | |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Facial pain/tics | |
| <input type="checkbox"/> Eye pain/strain | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sores in mouth | |

Respiratory System:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Throat phlegm |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain while breathing | | |

Cardiovascular System:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial valve |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Swelling of limbs | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Chest pain |

Gastrointestinal System:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Incomplete bowel movements | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Gas or burping | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Black stool | <input type="checkbox"/> Mucus in stool |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Hard stool | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Floating stool | <input type="checkbox"/> Change in thirst |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Itching around rectum |
| <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Known parasites | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Jaundice |

How often do you have a bowel movement? _____

Genito-urinary System:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Awaken to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urgency on urination | <input type="checkbox"/> Mucus in urine | <input type="checkbox"/> Strong urine odour | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Strain to urinate |

Muscle, Bones and Joints:

- | | | | |
|------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial joint |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Other pain |

Male Reproductive System:

- Hernia
- Discharges or sores
- Testicular pain
- Testicular mass
- Sexual difficulties
- Painful erections
- STD/ STI
- Impotence
- Low sexual drive
- Prostate condition

What is your sexual orientation? _____

Have you ever engaged in sexual intercourse/ currently sexually active? Yes No

(If over 50) When was your last prostate exam? _____

Female Reproductive System:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> PMS symptoms: | BREAST HEALTH: |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Cravings | <input type="checkbox"/> Fibrocystic breasts |
| <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Clots during period | <input type="checkbox"/> Sore breasts | <input type="checkbox"/> Sore breasts |
| <input type="checkbox"/> Abnormal PAP tests | <input type="checkbox"/> Light periods | <input type="checkbox"/> Cramps | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Sores, growths, lumps | <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Skin puckering |
| <input type="checkbox"/> Odour to discharge | <input type="checkbox"/> Infertility | <input type="checkbox"/> Low back ache | <input type="checkbox"/> Lump |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Missed periods | <input type="checkbox"/> Bloating | <input type="checkbox"/> Dry skin on nipple |
| <input type="checkbox"/> Pain during intercourse | <input type="checkbox"/> Recurrent yeast infections | <input type="checkbox"/> Diarrhea | |
| | <input type="checkbox"/> STD/ STI | <input type="checkbox"/> Headaches | |
| | | <input type="checkbox"/> Water retention | |

Age of first menses: _____ Age of last menses (if menopausal): _____

Length of cycle (time between the onset of one period to the onset of the next): _____

For how long do you usually bleed on average? _____ days

How many pads/ tampons do you use on the heaviest day of your cycle? _____

Date of last PAP: _____ Have you ever had an abnormal PAP test result? Yes No

What is your sexual orientation? _____

Have you ever engaged in sexual intercourse/ currently sexually active? Yes No

Do you practice birth control? Yes No What type of birth control currently used? _____

What types of birth control have you used in the past? _____

Have you ever used an IUD? Yes No Have you ever used birth control pills? Yes No

Are you pregnant? Yes No Are you trying to conceive? _____

Number of: Pregnancies: _____ Abortions: _____ Miscarriages: _____ Live births: _____

Do you perform monthly self-breast exams? Yes No, Are you familiar with how to perform a self-breast exam?

Date of last breast exam: _____ Do you have regular mammograms? Yes, how often _____ No

Additional comments/ Anything you would like to share that hasn't already been covered:

How did you hear about our clinic? _____

SIGNATURE

I, _____ attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

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CONSENT TO SERVICES FORM

FEE SCHEDULE:

Office Visits *All Fees Include HST*:

Initial Visit (approx. 90 mins.)	\$220
60 minute visit	\$139
45 minute visit	\$110
30 minute visit	\$75
15 minute visit	\$37

Naturopathic Acupuncture Visit (approx. 45-60 minutes) \$85

** Same fee schedule applies to telephone consults.*

** Please note that telephone consultations are generally intended for follow-up consultation and clarification of treatment protocols. Telephone consults are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated. It is required that you leave a credit card number on file in order to bill for a telephone consult.*

Laboratory Diagnostic Services:

Michelle Richea, ND will conduct a thorough case history, which will include an assessment of vitals and physical exam where indicated. Specific blood and/or urinary laboratory testing may be used as part of the diagnostic work-up.

Laboratory tests are Individually priced. All associated costs will be made aware to the client upon recommendation of specific laboratory services.

Herbal Dispensary & Naturopathic Medicines:

Michelle may recommend that you take certain products as part of your treatment plan. Please note that you are free to choose where you purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors.

All associated costs will be made aware to the client upon recommendation of specific health products.

Michelle Richea, ND offers an herbal dispensary for the compounding of botanical tinctures specific to the treatment protocol prescribed. Michelle also carries a limited selection of professional quality products that are not available through health food stores. OHIP does not cover the cost of these products, thus, patients are required to pay for products that they choose to purchase.

Booking Appointments:

Please schedule your appointments, including pick-up of prescribed products, in advance. Please plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

Payment for Services:

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain this receipt for your insurance or income tax claims, if applicable. Fees may be paid by cash, cheque, direct debit, Visa, or MasterCard. A surcharge of \$40.00 will apply to all NSF cheques. Please note that refunds are not available for medical services rendered, including lab tests performed. Extended health benefit plans often offer limited coverage for naturopathic medicine. Plans and policies differ, so please check with your provider regarding your coverage and claim procedures.

Cancelled and Missed Appointments

Please ensure to give at least 24 hrs. cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, a fee of \$40 will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the office manager.

Confidentiality

Everything that you communicate, directly or indirectly, to Michelle Richea, ND is confidential, unless you give written permission to disclose information to a third party. Confidentiality is respected at all times.

It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with a court ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient

In Case of Emergency

Emergency medical services are not offered by Michelle Richea, ND. In case of an emergency, patients should dial 911, or proceed to the Emergency Department of the nearest hospital.

Statement of Acknowledgment

I, _____ have read, understood and agree to the contents herein:
(print name)

Client Signature: _____ Date: _____

****Please sign and return this form to your Naturopathic Doctor on your first visit***

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PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of the business practices at The Clinic @ College Corner, while at the same time 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.

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. The reception staff will require your name, telephone number, and address when booking your first appointment. The health file that you create with Michelle Richea, ND is completely confidential and not shared with anyone else, unless you request otherwise by signing a consent form for the release of records.

Our privacy policy outlines what Michelle Richea, ND 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 the Naturopathic Doctors' regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Michelle Richea, ND understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how your information is used and disclosed. Michelle Richea, ND, will collect, use and disclose information about you for the following purposes:

- To assess your health concerns and provide appropriate 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 invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing this Patient Consent Form, you have agreed that you have given your 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 the Michelle Richea, ND will use my personal information, and the steps that they are taking to protect my information.

I agree that Michelle Richea, ND can use and disclose personal information about

_____ as set out above in the information Michelle Richea's privacy policies.
(Patient Name)

Signature

Print name

Date

****Please sign and return this form to your Naturopathic Doctor on your first visit.***

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CONSENT TO TREAT FORM

Statement of Consent

Name (please print): _____

As a patient of this practice I have read the information and understand that the form of medical care is based on Naturopathic Medical principles. I acknowledge that my Naturopathic Doctor, Michelle Richea, ND, endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results. I also recognize that even the gentlest therapies potentially have their complications in certain situations and hence the information provided is complete and inclusive of all health concerns, medical history, including risk of pregnancy; and all medications, including over-the-counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations.

I also acknowledge that I have the ability to accept or reject this care of my own free will and choice. I give permission and consent to Michelle Richea, ND, to provide naturopathic consultation, assessment and/or treatment to me [and/or my child _____ who is my son/daughter].

Client/ Guardian Signature: _____

Date: _____

****Please sign and return this form to your Naturopathic Doctor on your first visit.***

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Authorization for Release of Medical Information from Healthcare Professional

To: Dr.: _____
(please print)

From: Patient: _____
(please print)

Fax No#: _____

Date of Birth: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

X-Rays _____

Laboratory Results _____

Other _____

On behalf of Michelle Richea, N.D., I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: _____

Date: _____

Michelle Richea, ND
Registration #1466

Signature: _____

Date: _____

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(F) 416.923.2249

The Student Preceptor Program

There are only two naturopathic medical colleges in Canada - one in British Columbia, and one situated here in Toronto. In order for a naturopathic student to complete the 4-year program, he/she must fulfill a certain number of 'preceptor' hours. These are clinical requirements for students to witness a number of naturopathic sessions as a non-interactive observer. The students do not engage in these sessions, but simply participate as a silent observer. This is an important aspect of the naturopathic college's clinical education as this offers valuable insight into clinical practice. The students have complete understanding of the confidential nature of these sessions and uphold all requirements of full confidentiality. Your Naturopath, Michelle Richea, ND participates in this mentorship program and would like to know if you are interested in participating as well by allowing a naturopathic student to sit-in on your clinic visits. Of course, you are more than welcome to change your mind at any time, simply tell your ND or the office receptionist.

I understand the preceptor program, and:

- I would NOT like to participate
- I would like to participate by allowing a naturopathic student to sit-in on my clinic visits (If checked, please complete below)

CONSENT TO NATUROPATHIC STUDENT PRECEPTORS

I _____ (please print name) give my informed consent to allow naturopathic students to sit-in on my naturopathic visits for educational purposes. I understand that I can change my decision at any time by notifying the clinic receptionist or Naturopathic Doctor

Signature

Date