

## Medical Care - Informed Consent

**PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT WITH A MEDICAL DOCTOR AT IHI**

Accessing the opinion of a medical doctor is an important aspect of the integrative services offered at the Integrative Health Institute. The medical doctors at IHI can provide acute walk-in style healthcare for existing IHI patients. Although we will always endeavor to have a medical doctor available to our patients to assist in our collaborative care model, IHI medical doctors cannot serve as your long-term primary care physician.

In order to provide safe and effective collaborative care, it is important that you inform your doctor of any supplements, medications or over the counter drugs you are currently taking. If other practitioners at IHI are treating you, it should also be understood, that your medical doctor, as a member of your healthcare team, may confidentially discuss your case with your other practitioners at the Integrative Health Institute.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

While the majority of services provided by medical doctors in Ontario are covered by OHIP, the following items are subject to an additional fee (+gst) for the patient:

- Missed Appointments | \$30
- Medical notes of any kind | \$20
- MTO forms | \$100
- Company or camp medical forms | \$100

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 unless so directed by myself or required by law. If required, I understand that my medical doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee of \$0.10 per page.

Patient Name: (Please print name): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ MD Signature: \_\_\_\_\_

The vision of the Integrative Health Institute is to provide true integrative medical services. Given our commitment to this best-patient practice, we will communicate with your other medical providers at the clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.

**I welcome professional dialogue regarding my case between members of my medical team at the Integrative Health Institute: Yes | No**

Signature: \_\_\_\_\_