APPLE NATUROPATHIC

CONSENT TO TREAT

Cancelled and Missed Appointments

Please ensure to give at least 24 hours cancellation notice. We are then able to give the appointment time to another patient. If we do not receive sufficient cancellation notice, patients will be charged the full fee equivalent to the amount of time booked. Consideration will be given to unforeseeable circumstances, at the discretion of the Naturopathic doctor.

Payment for Services

Please note that we do not offer direct billing. Payment for services and dispensary items is due in full, at the end of each visit. 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 Visa, MasterCard, debit, cash, or cheque. A surcharge of $35.00 will apply to any NSF cheques. Please note that refunds are not available for medical services rendered, including lab tests performed and products that have been sold. Extended Health insurance plans often offer coverage for naturopathic medicine. Plans and policies differ, so please check with your insurance provider regarding your specific coverage and claim procedures.

Privacy Policy

Privacy of your personal information is an important part of naturopathic practice at Apple Naturopathic Clinic. We are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information, and are trained in the appropriate use and protection of your information. Our privacy protocols comply with privacy legislation (PHIPA) and standards of Dr. Kneeland's regulatory body, the C.N.P.B.C.

Confidentiality

Everything that you communicate directly or indirectly to Dr. Kneeland is confidential unless you give written permission to disclose information to a third party. Confidentiality is respected at all times. Exceptions to confidentiality 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 CALL 911

Emergency services are not available at Apple Naturopathic Clinic.

Statement of Consent

As a patient (or Parent/Guardian*) of Dr. Kneeland's Naturopathic practice I understand that Dr. Kneeland uses best practices to provide diagnosis and course of treatment, but that many factors may influence results and that no warranty is made with respect to any treatment, action or medical advice given. The information I have provided on my intake form is complete and includes all health concerns including the possibility of pregnancy, all medications I am taking, including over-the-counter drugs and supplements and any allergies I may have. I understand that Dr. Kneeland relies on these details to provide safe and appropriate treatments. I agree to discuss any changes in pregnancy status, medications, supplement or new allergies with Dr. Kneeland as soon as I am aware of them, as Dr. Kneeland may need to modify my treatment plan accordingly. I also recognize that even the gentlest of therapies might have complications. The possible health risks of some naturopathic medical treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, 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 right to accept or reject this medical care of my own free will and choice.

I, _____(PRINT NAME) have read, understood and agree to the contents herein.
_____(SIGNATURE) DATE _____

Parent/Guardian*
I give permission and consent to Dr. Kneeland, to provide Naturopathic medical consultation, assessment and/or treatment to my child _____(PRINT CHILDS NAME)
_____(PARENT/GUARDIAN SIGNATURE) DATE_____