 

PATIENT CONSENT FORM

This document provides details about our services, treatment protocols, personal information required and management of such information. We require your consent to collaborate with you in defining an individualized treatment plan that is best suited for you.

A. Homeopathic Treatment Plan:

We shall define a customized treatment plan based on your health history, physical, mental, emotional response to life events and modalities that aggravate or alleviate your symptoms. The outcome and duration of homeopathic treatment is individualized and cannot be replicated across patients or underlying health conditions.

Homeopathic remedies are intended to heal bodily symptoms or dysfunctions, in normalizing the body's physiological and mental state. The patient needs to follow the personalized treatment plan for administration and dosage.

Homeopathic remedies can sometimes cause a possible aggravation of symptoms existing prior to use of homeopathy including the reappearance of old symptoms and/or the temporarily aggravation of current symptoms as part of the healing process. If the patient experiences any problems associated with the remedy, they should suspend remedy consumption and contact the homeopath for advice.

Patients have the option of seeking/continuing allopathic (conventional) medical care from a medical doctor. Homeopathic treatment and medical treatment are different, but not mutually exclusive. It is patient's responsibility to maintain a relationship with a licensed physician for appropriate evaluations and emergency access. Homeopathic advice should not be taken as a medical diagnosis or as direction against a licensed medical or mental health care professional.

B. Communication:

If you have any questions or concerns about any part of the homeopathic process or if you would like to contact us team, please email at appointments@youniqueremedies.com We will try to respond to your messages soonest possible.

C. Fee and Cancellation Policy:

Appointment fee is for initial and follow up consultations. This does not include remedy cost, which could vary depending upon the prescription of the patient. No shows on account of appointments not cancelled or rescheduled 24 hours before the scheduled time will be reassigned and charged in full for the cost of the appointment. For initial appointments booked, we need to receive all consent and intake forms at least 48 hours before the scheduled appointment, failing which, the initial consultations will be cancelled, and you will be charged in full if we do not receive your paper work within this time frame.

 

D. Your Personal Information

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To provide health care and advise you of treatment options
- To establish and maintain contact with you
- To allow us to efficiently follow-up for treatment
- To complete claims for insurance purposes
- To process payments and invoice you for goods and services
- 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

The privacy of your personal information is utmost important to us. We, therefore,

- Collect only information necessary for us to determine the best remedy for you
- Only share your information with your consent, except as required by law
- Store, retain and destroy your personal information in compliance with existing legislation, and privacy protection protocols
- Comply with privacy legislation and standards of the regulatory body

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PATIENT CONSENT

I have reviewed the above information that explains how my individualized treatment plan would be developed and how my personal information will be used. I therefore consent to abide by the terms and conditions as laid out above.

Patient /Guardian Name: _____ Email: _____ Phone:_____

Address:_____

Emergency Contact – Name: _____ / Phone no. _____
Family Physician – Name: _____ / Phone: _____
I consent to contacting my Family Physician in case of emergency – Yes / No

Credit Card No: | | | | | | | | | | | | | | | | Expiry D D / Y Y

Signature of Patient or Guardian: Date:_____