

Health and Wellness Application and Client Services Agreement

I, _____, apply to obtain consultation services from _____ I understand that the services provided by _____ are intended to provide an integrative approach to health maintenance and quality of life through a multidisciplinary approach to my care. I understand also that _____ operate in a manner very different from a conventional primary care or family practice and that the services which are provided are not considered to be medically necessary and are not therefore reimbursable by the Ontario Health Insurance Plan ("OHIP").

Health and Wellness Fees

I understand the initial consultation fee is \$437.50. Follow-up consultation and treatment planning will be charged at \$350.00 and further follow-up appointments will average \$175.00 per session, (unless in rare circumstances, more time is required and these appointments will be charged accordingly, with my beforehand knowledge). Yearly re-assessment appointments may be suggested and will be \$325.00. I further accept and understand that such fees are my personal responsibility and may be increased over time.

Health and Wellness Services Provided to Clients

As a client of _____ I understand that a broad range of personalized services are made available to me, including an overall health and wellness review by _____, a customized preventative approach addressing lifestyle practices that influence well-being, an analysis of my personal health risks and addressing issues before they grow to negatively impact my health. In addition, I understand that I am agreeing to pay for a personalized, proactive, long-term health plan provided in a form that is useful and effective and designed to maximize vitality and help me live life to its fullest. It has been explained to me that amongst other things, the therapies which may be recommended to me by _____ may include meditation, life-coaching and counseling, nutrition, supplements, herbs, bioidentical hormones, low dose naltrexone, the perfect gene diet, acupuncture, physical activity, therapeutic massage, chiropractic, mind/body techniques and energy therapies.

I understand completely that the fees which I will be required to pay to _____ are for services that are not considered to be insured services by the Ontario Health Insurance Plan ("OHIP"). I understand fully that while Dr. _____ is a licensed physician and a member of the Canadian College of Family Physicians, she is not practicing family or conventional medicine in the context of the IMCI program and she is not providing me with the services that would be generally provided by a family physician in Ontario.

It has further been explained to me that I may also chose to access additional professional services such as nutritionists, physiotherapists, chiropractors or other health professionals and that these additional professional services if provided to me will be billed on a fee for service basis unrelated to the fees paid to IMCI for my integrative health and wellness profile.

Contacting MD

Dr. _____ is available for inquiries in (City), (phone number)

Cancellation, No Show Policy

I understand that I am required to provide 3 business days cancellation notice, otherwise I am responsible to pay for the missed appointment in full. I understand that in order to enforce the cancellation policy, my credit card information will be held on file and only charged if I cancel less than 3 business days prior to the appointment.

Prescription Renewals and Phone/Email Advice

I understand that prescription renewals without an appointment are \$40.00 per prescription and that all renewals will be done on the next day that Dr. _____ is in the clinic.

Telephone/email communication and advice with Dr. _____ will be charged to me accordingly and are my personal responsibility.

Medically Necessary Services

I understand that Dr. _____ will arrange, if requested, for any medically-necessary services, investigations and medical referrals (reimbursed by the Ontario Health Insurance Plan) to be provided to me by the appropriate medical practitioners and consultants as required.

Access to Personal Health Information

I understand that _____ complies fully with the requirements of the *Personal Health Information Protection Act, 2004*. As a client of the IMCI, I agree that Dr. _____ and other allied healthcare team members may access any electronic chart or health records to provide the most informed care possible. My health information from other healthcare providers and services may also be requested by _____ and I will be asked permission for this information to be provided to _____ on an as-needed basis. I may also be referred for a specialized service that is not generally provided by IMCI and this referral will be discussed with me and with my approval, necessary information will be provided to facilitate this referral.

Completion of Services at _____

I understand that _____ strive to provide the highest quality preventative healthcare to its clients. I agree to work in collaboration and consultation with Dr. _____ and any other allied healthcare team members to improve my overall health and well-being. However, should the Medical Director, Dr. _____, determine that _____ is not able to continue to provide high-quality health and wellness care for me, for any reason, I will be advised of this decision and any fees I may have paid for services that had not already been rendered at the time of such decision, will be refunded to me on a pro-rata basis.

Client

Witness

Date _____